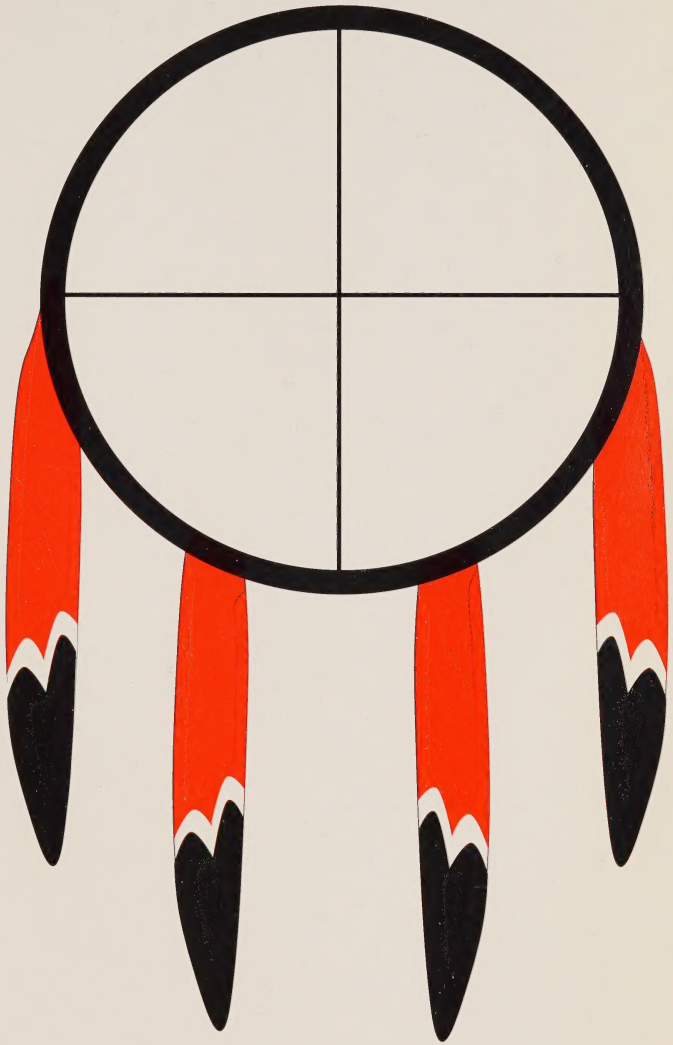
REPORT ON THE FUTURE MANAGEMENT OF THE NON-INSURED HEALTH BENEFITS PROGRAM

Volume I



Assembly of First Nations

Health Canada

The Report and Recommendations of the Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Volume One

February 1996

The Joint AFN/MSB Task Force Report
Table of Contents

Volume One

Preface

Letters from the Co-Chairs
Chief Sydney Garrioch
and
Paul Glover

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Preface
Letters from the Co-Chairs

Chief Sydney Garrioch
Cross Lake First Nation

After more than two years of work, we are finally able to present this Report. By way of this letter, I offer my personal observations on the work produced and on this particular "partnership" journey.

First, however, I wish to express my appreciation for the commitment of time and effort given to this task by the other Chiefs, former Chiefs and our Technical Support Team who have worked on the Task Force with me. They have spent much time away from their families and communities. They have worked and fought hard for the principles that we, the descendants of the original people, hold sacred. They have not wavered in their efforts to improve health services for all Inuit, Innu and First Nations.

I hope that the readers of this Report will acknowledge their efforts and sacrifices. To them I say in my own language: Ekosi - Thank You!

The Report itself did not end up the way I would have anticipated as we began the journey in October, 1993. I am disappointed that we did not make greater gains in advancing our principles, such as the Aboriginal and First Nation Treaty Right to Health. I had also hoped that one or two management options would emerge as a clear way by which we could guarantee good future

Paul Glover
Medical Services Branch

The completion of this Report on Future Management Options for the Non-Insured Health Benefits (NIHB) Program fulfils the mandate assigned to the Joint Task Force (JTF) by the Deputy Minister of Health Canada and the National Chief of the Assembly of First Nations (AFN).

The Report is the result of over two years of effort, hard work, commitment and support by the Members of the JTF and the Technical Working Group (TWG). I thank them for their support and cooperation throughout this process. The TWG provided never-ending support to the JTF and I especially thank them for all their efforts.

To those First Nations, Innu and the Inuit who participated in the Consultation Process, I thank you for welcoming us into your communities. I recognize that there are many priorities facing the First Nations, Innu and Inuit communities and I appreciate the time you took to share your views and opinions on this important Program. Your suggestions and opinions were of great assistance to the JTF during our deliberations and when making Recommendations.

During the last two years the Medical Services Branch (MSB) representatives always attempted to work as equal partners with their AFN colleagues on the JTF. The

health services under our own control. This, clearly, did not occur. However, I do believe that the Recommendations contained in the Report offer some improvements to the current Non-Insured Health Benefits Program. I believe they also show some ways for us to continue the move toward our people managing their own health services. Most important though, the Report reflects what our people and their leaders and administrators told us as our Consultation Team travelled across the country seeking opinions. We have made every effort to see that these opinions were not diluted or modified, and I hope this can be seen throughout the Report.

I was also disappointed that the goal of an "equal partnership" approach did not turn out to be exactly that. This failure cannot be laid completely on the shoulders of the five Medical Services Branch officials who served with us on the Task Force. As I have said publicly on more than one occasion, they are conscientious civil servants who have attempted to understand our perspectives and our assertions about our sacred Aboriginal and Treaty Rights. That being said, however, I must tell you that we did not achieve some of the very basic changes to the relationship between our People and the federal government that I was hoping for as we began this journey. When secret, arbitrary and unilateral decisions continued to be made by Medical Services Branch as the Task Force was doing its work, I had to conclude that the relationship was more "unequal" than "equal". Indeed, as I was thinking about what words to put into this letter, I received official notification from Medical Services Branch of

JTF was limited, however, by its mandate to deal specifically with identifying the future management options for the NIHB Program. Therefore, the day-to-day management of the NIHB Program, including the enforcement of the NIHB Directives, continued to be the responsibility of MSB. One of the Recommendations of the JTF is the establishment of both National and Regional Joint Decision-Making Bodies which would share the responsibility for the management of the NIHB Program. Through this process I look forward to a new working relationship with the First Nations, the Inuit and the Innu in managing the NIHB Program as recommended by the JTF.

The two-phased Consultation Process which was used by the JTF was unique in that it was the first time that community representatives were involved in such comprehensive discussions. Phase I provided representatives from First Nation, Innu and Inuit communities with detailed information about the NIHB Program and its related management issues. This ensured that there was a common understanding of the Program from which to base recommendations about its future management. Phase II involved returning to the communities to obtain their views and opinions on the future management options for the NIHB Program. We have included these views, suggestions and opinions in this Report verbatim, as they were presented to our Consultation Team and to the JTF.

Chief Sydney Garrioch

changes and reductions to dental services that were made without our involvement !

On several occasions those of us on the Aboriginal side almost decided to walk away from the Task Force because of this inequality. However, in each instance we chose to remain and work for change from within. And we did make some gains, such as the government commitment to have an Aboriginal presence in the drafting of a Cabinet document concerning a renewed mandate for the Non-Insured Health Benefits Program. But the fundamental changes needed in the relationship between the original people and government are still before us.

I believe that those who come behind us in this work must continue efforts to change this basic relationship. Remember that we are dealing with relationships that have been unequal for generations and that real change is very, very difficult to achieve even in the best of times. And, as we head into a period of apparently prolonged government reductions in spending, these are hardly the best of times for our People.

Despite the difficult times we are living through, I know that we are getting stronger as a people and that there are many reasons for hope. I have no doubt that the Creator will continue to guide us and strengthen us in our quest for justice and a peaceful, healthy life within Canadian society. In this Report there are some avenues of hope and some commitments toward future change. I urge both the Aboriginal and the government

Paul Glover

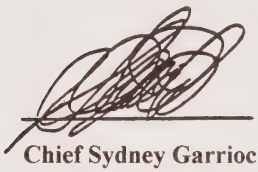
It was a difficult time in which to be consulting with the communities. When we first established the JTF the Indian Health Services
Envelope did not exist. Also, during the Consultation Process, the potential "five options for managing the Envelope" were shared with you. The introduction of these new elements certainly made the Consultation Process more difficult.

So that we may ensure continued progress and improvement in the management of the NIHB Program, it is important to view this Report as a beginning and not as an end in our working relationship with the First Nations, Innu and Inuit. Many of the Recommendations contained in this Report are intended to further develop that working relationship, allowing it to evolve from making joint recommendations to one of joint decision making on all MSB Programs.

This journey will not be easy given the views and requirements of the First Nations and MSB's need to manage all Programs, including NIHB, within the First Nations and Inuit Health Services Envelope.

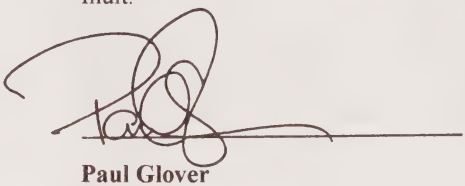
representatives to pursue them with vigour in the months ahead.

And, finally, I would like to thank all those who have shown me support and kindness throughout this journey. It was an honour to be chosen to serve. Ekosi!!!!!



Chief Sydney Garrioch
Cross Lake First Nation

I am confident, given the progress we have made over the last two years, that together we will achieve much in the coming years. I look forward to the challenges that lie ahead of us and to the establishment of a new working relationship with the First Nations, Innu and Inuit.



Paul Glover
Medical Services Branch

Section One

Membership of the Joint Task Force

The Joint AFN/MSB Task Force
on the
Future Management
of the
Non-Insured Health Benefits Program

Section One
Membership of the Joint AFN/MSB Task Force

Assembly of First Nations | **Medical Services Branch**

The Co-Chairs

Chief Sydney Garrioch
Cross Lake First Nation

Paul Glover[1]
A/Director General, NIHB

The Members

Chief Terry Paul
Membertou First Nation

Al Garman[2]
Regional Director, Atlantic

Chief Jean-Charles Pietacho
Mingan First Nation

Richard Legault[3]
Regional Director, Quebec

Chief Nora Bothwell[4]
Alderville First Nation

Abu Nazir[5]
A/Regional Director, Ontario

Chief Bernadette Unka[6]
Deninu K'ue First Nation

Jerome Berthelette[7]
DG, Program Policy Transfer
Secretariat and Planning

The Technical Working Group

Allen Deleary
Michael Burdett
Lee Morrison
John Robson

Joanne Meyer
Herman Wierenga
Roberta Greyeyes

Acknowledgements

The Joint Task Force wishes to acknowledge the dedication demonstrated by Diane McGregor in her capacity as an Executive Assistant to Chief Pietacho.

The Joint Task Force also wishes to acknowledge the contributions made by:

Francine Martel
Melanie Musgrove
Lucille Paquette

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1. Paul Cochrane resigned as Co-Chair when he was appointed Acting Assistant Deputy Minister and was replaced by Paul Glover, Acting Director General, NIHB.

2. Al Garman replaced Joanne Meyer as a member of the Joint Task Force. Joanne Meyer resigned as a member of the JTF upon her transfer to Ottawa and continued to support the Joint Task Force as a member of the Technical Working Group.

3. Richard Legault replaced Claude Paradis as a member of the Joint Task Force in January 1996. Claude Paradis retired after a long and distinguished career with the public service.

4. Chief Nora Bothwell replaced Chief Leona Nahwegahbow after her resignation from the Joint Task Force. Although eventually losing her position as Chief, the National Chief, in the interests of continuity and consistency, decided that she should continue as a full member of the Joint Task Force.

5. Abu Nazir replaced Richard Jock as a member of the Joint Task Force in January 1996. Richard Jock had previously replaced Helene Quesnel upon her reassignment to other duties.

6. Chief Bernadette Unka was appointed as a member of the Joint Task Force after the resignation of Chief Jim Badger. Although eventually losing her position as Chief, the National Chief, in the interests of continuity and consistency, decided that she should continue as a full member of the Joint Task Force.

7. Jerome Berthelette was appointed as a member of the Joint Task Force upon the resignation of Ginette Thomas.

Section Two

Executive Summary

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Section Two
Executive Summary

1. Background

The Non-Insured Health Benefits (NIHB) Program, which is currently managed by Medical Services Branch (MSB), Health Canada, provides First Nations and Recognized Inuit[1] with medically necessary drugs, Medical and Surgical Supplies and Equipment, Dental Care Services, Vision Care and the transportation necessary to receive medical care.

A Joint Task Force (JTF) was formed in June 1993 to examine future management options for the NIHB Program. The JTF was composed of five representatives each from the Assembly of First Nations (AFN) and from MSB. The full membership is detailed in Section One of this Report and the Terms of Reference are reproduced in Appendix "B".

The JTF developed a two-stage Consultation Process through which the First Nations communities were invited to make recommendations on the NIHB Program. The implementation of the Consultation Process in the various Regions is described in Section Four of this Report. The transcripts of the various Consultation Sessions and the written responses that were submitted to the JTF are compiled to form Appendix "H" in Volume Two of this Report.

This Consultation Process was repeated in the Northwest Territories to obtain the recommendations of the Inuit and the First Nations in the North. Similarly, comments and recommendations were invited from those First Nations members who live Off-Reserve. These recommendations will be published in two separate Reports.

2. The Joint Task Force Recommendations

Section Five of this Report contains the full details of the 20 Recommendations made by the JTF. This Section also describes the background to each Recommendation, referencing the suggestions and comments from the First Nation participants during the Consultation Process. Appendix "A" contains the compiled Recommendations, for ease of reference.

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[1] The term "First Nations" in the context of this Report includes those Indians either registered or eligible for registration with DIAND and also Innu.

The First Nations participants recommended that no major decisions be made concerning the future management of this important Program until after the completion and evaluation of the 30 NIHB Pilot Projects. These Pilot Projects are intended to test the viability of various management options and to form a basis from which the First Nations could make sound decisions on their choices for the delivery of the NIHB Program in the future. The management options most favoured by the First Nations were those which they considered did not weaken either the Treaty Right to Health or the Fiduciary Responsibilities of the Federal Crown. Consequently, no one specific option was selected for the future management of the NIHB Program.

The NIHB Program was excluded from the authority given to MSB to transfer responsibility for the delivery of community health services to First Nations communities. There was an agreement by the JTF that MSB should not seek any additional authority until after completion and evaluation of the NIHB Pilot Projects.

The JTF recommended the establishment of Core Principles and Core Benefits which should be implemented and universally available in all MSB Regions and by First Nations and Inuit communities and organizations which manage the NIHB Program.

There was a unanimous recommendation that Non-Insured Health Benefits should continue to be provided to the On and Off-Reserve Registered Indians, Innu and Recognized Inuit of Canada, without regard to their financial status.

The First Nations participants throughout the Consultation Process expressed the opinion that no changes should be made to health services without their agreement. In keeping with the spirit of this advice, the JTF recommended the establishment of Joint Decision-Making Bodies at the national and regional levels.

3. The Next Steps

The JTF recognized that some of the activities that it had initiated, such as the establishment of a Joint Selection Committee for NIHB Pilot Projects, would not be concluded until after the Task Force had completed its term. Other initiatives which were recommended by the JTF, such as the implementation of Joint Decision-Making Bodies, would not commence until after the acceptance of the final Report by the National Chief and the Deputy Minister.

In addition, MSB made some specific commitments to the AFN representatives on the JTF that it would review some aspects of the NIHB Program. This review is to be based on the recommendations made by the First Nations during the Consultation Process.

Section Six of the JTF Report addresses these areas where action is required either jointly by MSB and the AFN or by MSB alone subsequent to the release of the JTF Report. Where the JTF did not make a recommendation and follow-up is required a description of the follow-up action necessary is included in this Section.

Section Three

Introduction and Background

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Section Three
Introduction and Background

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1. The Joint Task Force

In 1992, the National Chief of the Assembly of First Nations, Ovide Mercredi and the Deputy Minister, Health Canada, Jean Jacques Noreau held discussions regarding the Non-Insured Health Benefits (NIHB) Program. These discussions focused on such issues as:

a. the First Nations' concerns regarding the implementation of national NIHB Directives;
b. the Blue Cross contractual arrangement;
c. NIHB Program management and administration;
d. the transfer of NIHB to First Nations control;
e. Government concerns about the rising cost of service provision.

As a result of these meetings, the National Chief and the Deputy Minister agreed in June 1993 to develop a partnership approach aimed at addressing these concerns. The Deputy Minister and the National Chief jointly approved the mandate for the AFN/MSB Joint Task Force and each selected representatives to sit as members.

The AFN/MSB Joint Task Force on the Future Management of Non-Insured Health Benefits was composed of five representatives each from the Assembly of First Nations and from Medical Services Branch. Chief Sydney Garrioch, Cross Lake First Nation, Manitoba was appointed as the Co-Chair for the AFN. Paul Cochrane, then Director General, NIHB, was appointed as the Co-Chair for MSB and, upon his promotion to Acting Deputy Minister, was replaced in September 1994 by Paul Glover, Acting Director General, NIHB. A complete list of the members is included in Section One of this Report.

The first meeting of the AFN/MSB Joint Task Force (JTF) was held in October 1993. A total of 16 meetings were held at various locations throughout Canada. The JTF completed the mandate in February 1996.

2. The Technical Working Group

A Technical Working Group (TWG) was established in December 1993 to provide administrative support and technical advice to the members of the JTF. The members of this Technical Working Group are listed in Section One of this Report.

3. The Mandate of the Joint Task Force

The full mandate and Terms of Reference for the AFN/MSB Joint Task Force are attached in Appendix "B" of this Report. The mandate given to the JTF was:

"Through an equal partnership approach, the Joint AFN/MSB Task Force will develop a series of options for the future management of NIHB aimed at enhancing program effectiveness and efficiency and facilitating First Nations involvement and control."

4. The Northwest Territories

Although the mandate described above excluded the Inuit and Registered Indians living north of the 60th parallel, the AFN Chiefs lobbied extensively for their inclusion into the Consultation Process. In May 1995, MSB agreed to extend the JTF Consultation Process to include all First Nations[1] and Inuit communities across Canada, including the Northwest Territories.

At the time of writing this Report, Information/Orientation Sessions and Consultation Sessions were being carried out in the Northwest Territories for the First Nations and Inuit communities. The results of this Consultation Process will be published in a separate Report.

5. First Nations Members Living Off-Reserve

Over 50 percent of the First Nations membership live Off-Reserve, mostly in the major urban centres. Consequently, the JTF decided that it was necessary to extend the Consultation Process to include those First Nations members living in the major centres. At the time of writing this Report, Information and Consultation Sessions were being carried out in the major urban centres. The results of this Consultation Process will be published as a separate Report.

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[1] The term "First Nation" in the context of this Report includes thos Indians either registered or eligible for registration with DIAND and also Innu.

Section Four

The Joint Task Force Consultation Process

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Section Four
The Joint Task Force Consultation Process

1. Overview of the Consultation Process

The Terms of Reference for the Joint Task Force (JTF), attached in Appendix "B" of this Report, stated as the first Objective:

"To facilitate First Nations input into the Task Force review by:

a. soliciting First Nations input into the subjects under Task Force review;

b. reviewing the First Nations and MSB policy and position papers on NIHB; and

c. holding a series of Regional Task Force dialogues involving First Nations and MSB Regions on the subjects under Task Force review."

During the initial meetings of the JTF there was unanimous agreement that it was necessary to invite the recommendations and suggestions from each of the First Nations[1] and Inuit communities in Canada. There was also a realization that time and funding constraints precluded full consultation at the community level. Consequently, a compromise solution was developed.

The JTF developed a two stage consultation process. The first stage was strictly an information sharing component, where details of the NIHB Program and the JTF activities were provided to each community. The second stage, conducted some time after the first information stage, invited the input, recommendations and suggestions from community representatives.

2. The Information-Sharing Component

This first stage of the Consultation Process was intended to familiarize First Nation and Inuit communities with the activities of the JTF, the details of the NIHB Program and the difficulties involved in managing such a complex Program. This information was provided so that the First Nations and Inuit communities could make informed decisions and

[1] The term "First Nation" in the context of this Report also includes Innu.

recommendations regarding the future management of the Program in the second stage of the Consultation Process.

The sharing of information was done in several ways:

a. Distribution of Information Packages:

Two Information Packages were sent to the Chief and Council and to the Health Portfolio holders of each First Nation. The content of these packages was:

i. an introductory letter from the National Chief, Assembly of First Nations and the Deputy Minister, Health Canada;
ii. copies of the Joint Task Force Mandate and Terms of Reference;
iii. Workplan for the completion of the tasks;
iv. a letter from the two Co-Chairs;
v. Minutes of JTF meetings

b. Information/Orientation Session:

A minimum of a one half-day Information/Orientation Session was held in each Medical Services Branch Region. A representative from each First Nation and Inuit community was invited to attend this session. All travel and accommodation costs were provided by MSB, as were those costs that were associated with the provision of meeting rooms.

A list of the locations of these Information/Orientation Sessions is shown in Table 4.01, at the end of this Section.

c. The Minutes of Meetings:

The Minutes of the JTF meetings were distributed to all First Nations. By mutual agreement, the Assembly of First Nations assumed responsibility for the distribution of the Information Packages and subsequent Minutes to all aligned First Nations. MSB was responsible for the distribution to all non-aligned First Nations.

3. The Information/Orientation Sessions

At these Information/Orientation Sessions, two representatives from either the Technical Working Group or from the JTF provided detailed information to the participants. One representative from the AFN and one representative from MSB jointly presented the following information:

a. the background to the formation of the JTF;
b. the composition of the JTF and the Technical Working Group;
c. the Mandate and Terms of Reference of the JTF;
d. a description of the Consultation Process;
e. the current NIHB Program Benefits, Principles and Eligibility Criteria;
f. statistical information, showing program expenditures by Region, trends and variations;
g. the problems and pressures of the NIHB Program.

At the conclusion of the Information/Orientation Session, specific questions on the future of the NIHB Program were presented to the community representatives. The participants were asked to take the detailed information and the specific questions back to their home communities for discussion prior to the Consultation Session.

The specific questions to which suggestions, comments and recommendations were invited from the First Nations and Inuit communities were:

a. NIHB Key Program Elements:

What does your community recommend should be:

i. The Future Management Options for the NIHB Program;
ii. The Core Program Principles;
iii. The Core Benefits;
iv. The Eligibility Criteria.

b. NIHB Program Administrative Elements:

i. Should there be an Appeals Process and, if so, how should it work?
ii. How would eligible clients identify themselves to Suppliers of Service?
iii. Who should negotiate contracts with the Suppliers of Service?
iv. How should the payment process for benefits be administered?

It was expected that this detailed information when shared with the community members would be the focus of discussions and debate within the First Nations and Inuit communities. Two community members would then be selected to present the recommendations and suggestions at the Consultation Session.

4. The Consultation Component

The second component of the Consultation Process, after the Information-Sharing component, was consultation with the representatives from the First Nations, Innu and Inuit communities. This was achieved by two different methods, the Consultation Session and the Consultation Workbook.

5. The Consultation Session

A two-day Consultation Session was scheduled for some time after the Information/Orientation Session. This delay was to allow sufficient time for the communities to discuss the issues and questions that had been raised during the Information/Orientation Session. The Region was requested to follow up with the communities at the local level to ensure that the specific questions provided to the participants at the Orientation/Information Session were being used to discuss the NIHB Program and the future options.

The JTF designated two members of the Technical Working Group, Joanne Meyer, MSB and Michael Burdett, representing the AFN, as the primary facilitators for the Consultation Sessions.

Two representatives from each community were invited to attend the Consultation Session. The communities were requested to ensure that those individuals selected to attend were authorized to represent the community's views and recommendations for the future management of the NIHB Program.

MSB covered the costs of necessary travel, accommodation and meals for the community representatives to attend the Consultation Session.

At the Consultation Session, a brief recap of the Information/Orientation Session was provided. The majority of the Session focused on small group discussions, which were followed by the presentation of recommendations and suggestions on the future management of the NIHB Program in a plenary session.

The Region-specific implementation of this Consultation Process is described later in this Section of the Report.

The recommendations, suggestions and comments received through this process are reproduced verbatim in Appendix "H" in Volume Two of this Report. The locations of the communities participating at the various Consultation Sessions are listed at the end of this Section in Tables 4.02 to 4.09.

6. The Consultation Workbook

Realizing that there may be some interested parties who would be unable to attend the Consultation Sessions, the JTF also invited written submissions and recommendations from individuals, First Nations and Inuit communities and from Aboriginal organizations.

A Consultation Workbook was distributed to the First Nations and Inuit communities both at the Consultation Sessions and also by mail prior to the Sessions. This Consultation Workbook is reproduced in Appendix "C" and contains an overview of the NIHB Program and a list of specific questions. First Nations and Inuit communities were invited to complete the Workbooks and either leave them with the facilitators at the end of the Sessions or mail them to:

Joanne Meyer
Director
Joint Task Force Secretariat
Jeanne Mance Building, 9th Floor
Tunney's Pasture
Ottawa, Ontario
K1A 0L3

Michael Burdett
Health Consultant
Suite 111
207 Bank Street
Ottawa, Ontario
K2P 2N2

The First Nations and Inuit communities which chose to submit completed Consultation Workbooks are listed in Table 4.10 at the end of this Section. The recommendations received are listed verbatim in Appendix "H" in Volume Two of this Report.

7. The Implementation of the Consultation Process

The various MSB Regions were given the responsibility for organizing and coordinating both the Information/Orientation and the Consultation Sessions with the First Nations and Inuit in their specific Region. The JTF prepared and distributed the "Non-Insured Health Benefits Consultation Sessions Information Manual" to assist the Regions with organizing the Consultation Sessions.

The JTF made strong recommendations to the Regions that both the Information/Orientation Sessions and the Consultation Sessions be organized as a stand-alone process. The intent was to avoid the amalgamation of the JTF Sessions with any other discussions about other MSB programs, so that the participants could focus on the NIHB Program alone.

Despite this recommendation from the JTF, some Regions decided to combine the NIHB Orientation with consultation about other MSB Programs. Participants frequently complained of "information overload" and of the need to have an adequate amount of time

to discuss the issues involving the NIHB Program. In some cases, the time allocated for the Orientation/Information Session was restricted to an hour or less rather than the half-day recommended by the JTF.

The following is a synopsis of how the Consultation Process was implemented in each Region:

a. Atlantic Region:

i. Orientation:

The Region coordinated individual Information/Orientation Sessions for the Assembly of Nova Scotia Chiefs (ANSC), the Union of New Brunswick Indians (UNBI) and the Innu Nation Health Commission (INHC).

Additionally, an Information/Orientation session was held for the Labrador Inuit Health Commission (LIHC). The LIHC chose not to include community representation in its Information /Orientation Session.

ii. Consultation:

The Region coordinated individual consultations for both ANSC and UNBI. The UNBI Chiefs decided to extend the Consultation Process and organized a subsequent meeting to formulate recommendations. The transcript of their final submission is included in Appendix "H" in Volume Two of this Report.

A Consultation Session was held with the INHC but did not include community representatives. The LIHC declined the Consultation Process for its communities.

b. Quebec Region:

i. Orientation:

In the Quebec Region, a brief orientation to the NIHB Program and the work of the JTF was presented as part of the agenda for the Annual MSB/First Nations Operational Planning Meeting. This presentation was conducted by Headquarter's staff before the detailed NIHB Orientation/Information Session hand-out material was available for distribution.

The First Nations considered this brief presentation not to be a proper Orientation but only an overview of the NIHB Program.

ii. Consultation:

One Consultation Session was organized and coordinated by the Health and Social Services Commission of Quebec on behalf of all the First Nations and Innu in the Quebec Region. Many of the participants at the Consultation Session had not attended the original Information/Orientation Session.

Those participants who had attended the original Orientation/Information Session commented that the information presented at the Consultation Session was more detailed and comprehensive than that provided at the Information/Orientation Session. The participants attending the Consultation Session therefore requested by Band Council Resolution that a second Consultation Session be organized so that the community recommendations for the NIHB Program could be presented.

Although a second Consultation Session was not provided, the Regional Director extended a verbal invitation to work with individual First Nations on any NIHB issues. As a result, very few recommendations were received from the First Nations of Quebec.

c. Ontario Region:

i. Orientation:

The Region carried out seven three-day Information Sessions on a variety of MSB Program issues, including the NIHB Program. The JTF Consultation Team provided the Information/Orientation Sessions as a part of this Ontario Region process.

Initially, the Region decided that both the Information/Orientation Session and the Consultation Session would be combined into one meeting. The AFN Caucus of the JTF objected to this approach by the Ontario Region, as it did not allow time for community discussions. This Regional process was also not well accepted by the First Nations of Ontario and the full JTF Consultation Process was eventually adopted in Ontario Region.

ii. Consultation:

The Ontario Region left the organization of the Consultation Sessions to the First Nations. The First Nations organizations were advised to contact the JTF Consultation Team themselves if they wished to participate in the Consultation Process.

Consultation Sessions were held with all the First Nations groups, with the exception of the Association of Iroquois and Allied Indians (AIAI). The Consultation Team contacted AIAI, which declined to participate in the process.

d. Manitoba Region:

i. Orientation:

The Region delegated the coordination of the Information/Orientation Sessions to the Assembly of Manitoba Chiefs (AMC). The AMC organized one, large Information/Orientation Session to which all of the First Nations in Manitoba were invited.

ii. Consultation:

The AMC coordinated one Consultation Session for all of the First Nations in Manitoba, which was held in Winnipeg.

e. Saskatchewan:

i. Orientation:

The Region coordinated seven individual Information/Orientation Sessions with the various Tribal Councils in Saskatchewan. A representative from each of the Tribal Council member communities attended these Sessions.

ii. Consultation:

All First Nations in Saskatchewan were invited to attend a Health Workshop organized by the Federation of Saskatchewan Indian Nations (FSIN). The Consultation Team was allocated time at this Health Workshop to review the information that was presented at the Information/Orientation Sessions. The participants then broke into working groups.

The FSIN modified the Consultation Questions that were presented by the Consultation Team and the participants in the working groups focused on these revised questions. The FSIN submitted a written response on behalf of all the First Nations in Saskatchewan. This response is included in Volume 2, Appendix "H" of this Report.

f. Alberta Region:

i. Orientation:

Individual Information/Orientation Sessions were held for each of the three Treaty areas. Three Sessions were held, one each for Treaty 6, Treaty 7 and Treaty 8.

ii. Consultation:

The Consultation Sessions were organized by the Zone Directors for each Treaty Area. Four Consultation Sessions were held for the Treaty 8 First Nations; two Sessions were scheduled for Treaty 6 and one Session was held for Treaty 7.

The Chiefs of the Treaty 6 First Nations declined to participate in the Consultation Process.

g. Pacific Region:

i. Orientation:

The Region organized five three-day "pre-consultation sessions" with the Health Committee of the First Nations Summit. These pre-consultation sessions addressed a variety of MSB Program issues, including the NIHB Program.

The Health Committee of the First Nations Summit chose not to allocate the time necessary for the full NIHB Information/Orientation Session. The Consultation Team consequently was required to substantially abbreviate the presentations to fit the time allocated. In one instance, the Consultation Team was provided with only a 20 minute time slot.

Although this process did not follow the JTF format, the Consultation Team was able to provide the information packages to those who attended the sessions.

ii. Consultation:

Neither the Pacific Region nor the Health Committee of the First Nations Summit organized any Consultation Sessions. The JTF Report contains recommendations from only one of the Pacific Region First Nations.

The Region defined a local consultation process which would take place in three stages: pre-consultation, bilateral consultation and a Regional meeting. At these pre-consultation meetings, the participants were advised that further consultation would occur over the following months, at the specific invitation of the communities. The pre-consultation process was completed in March 1995.

Following the pre-consultation meetings, Zone Directors and other staff met with Bands and Tribal Councils in the course of their day-to-day operational duties. During these meetings, the Pacific Region reported that it was apparent that the First Nations in the Region had little interest in discussing the JTF issues on the NIHB Program.

h. Yukon Region:

i. Orientation:

The Region coordinated an Information/Orientation Session with the Council of Yukon Indians (CYI). Representatives from each community attended the Session.

ii. Consultation:

The Region and the CYI coordinated a Consultation Session in Whitehorse which was attended by representatives from each community.

8. First Nations' Comments on the Consultation Process

Many of the First Nations participants who attended the Consultation Sessions expressed the need for additional time in which to continue the consultation process with their community members. The question "what's the rush?" was frequently asked. The opinion was expressed that the responsibility for continuing the consultation at the community level was a difficult job after only a short Orientation Session.

Concern was expressed that any recommendations which were made would have a far-reaching effect on the future of the NIHB Program regarding future generations. Many participants expressed the need for MSB's assistance at the community level and requested that the Information/Orientation Session be provided at the community level.

First Nations have very clearly expressed the view that Consultation is an ongoing and important process. It was stated that an adequate time frame should be allocated without the imposition of any external pressures such as an arbitrary deadline for completion of the process.

Many participants, including Chiefs, Councilors and Elders, stated that the JTF should not make any recommendations on the Future Management Options for the NIHB Program until the results of the Pilot Projects were available.

9. Joint Task Force Observations on the Consultation Process

The JTF identified a number of issues which may be of interest for those who carry out consultation with First Nations in the future.

When planning the consultation process, the JTF envisaged that the individual attending the Orientation/Information Session would return for the Consultation Session. In the majority of cases, the individuals attending the Consultation Session did not include the individual who originally attended the Orientation/Information Session. In addition, in many cases the individuals attending the Consultation Session were not familiar with the NIHB material and were not aware that an Orientation/Information Session had taken place.

Many individuals also indicated that they did not come to the Consultation Session with a mandate to provide recommendations or suggestions on the NIHB Program on behalf of their community and therefore felt uncomfortable at being asked to make suggestions which they felt would affect their community.

Table 4.1: Locations of Information/Orientation Sessions

Region	Location	Tribal Council Member Nations
Atlantic	Fredericton Halifax Northwest River Sheshashit	Union of New Brunswick Indians Assembly of Nova Scotia Chiefs Labrador Inuit Health Commission Labrador Innu Health Commission
Quebec	Montreal	Quebec First Nations
Ontario	Fort Francis London Sudbury Thunder Bay Timmins Toronto Toronto	Treaty 3 First Nations Association of Iroquois & Allied Indians Union of Ontario Indians Nishnawbe-Aski Nation Nishnawbe-Aski Nation Union of Ontario Indians Independent First Nations
Manitoba	Dakota Tipi	Assembly of Manitoba Chiefs
Saskatchewan	Fort Qu'Appelle La Ronge Manitou Beach North Battleford North Battleford Yorkton Saskatoon	Touchwood File Hills Tribal Council Prince Albert Grand Council Saskatoon Tribal Council Battleford Tribal Council Confederation of Tribal Nations Yorkton Tribal Council Agency Chiefs
Alberta	Calgary Edmonton Edmonton	Treaty 7 First Nations Treaty 6 First Nations Treaty 8 First Nations
Pacific	Chilliwack Kamloops Port Hardy Prince George Terrace	South Mainland Zone First Nations South Mainland Zone First Nations Vancouver Island Zone First Nations North East Zone First Nations North West Zone First Nations
Yukon	Whitehorse	Council of Yukon Indians

Table 4.2: Locations of Consultation Sessions
Atlantic Region

Location	Participating First Nations
Halifax	Acadia Chapel Island Eskasoni Schubenacadie Membertou Wagmatcook Waycobah
St. Basille	Union of New Brunswick Indians
Sheshatshit	Labrador Innu Health Commission

Table 4.3: Locations of Consultation Sessions
Quebec Region

Location	Participating First Nations
Montreal	Akwesasne Betsiamites Eagle Village Gesgapegiag Kanesatake Khanawake Kitcisakik La Romaine Lac Simon Listugus Long Point Manouane Mashteuiatsh Micmacs de Gaspe Mingan Natashquan Obedjiwan Odanak Pikogan Schefferville (Matimekosh) St. Augustin Timiskaming Uashat Mak Mani-u-Tenam (Sept-Iles) Viger (Malecites) Wendake Weymontachie Wolinack Algonquin Tribal Council Atikamekw Sipi (conseil tribal) Mamit Innuat - Mingan (conseil tribal) Waskaganish (observateur)

Table 4.4: Locations of Consultation Sessions
Ontario Region

Location	Participating First Nations
Fort Francis	Big Grassy Big Island Eagle Lake Iskutewiskaygun #39 Lac La Croix Lac Seul Nicickousemenecaning Northwest Angle #33 Northwest Angle #37 Onegaming Rainy River Rat Portage Seine River Stanjikoming Wabaseemoong Wabauskang Wabigoon Whitefish
Moose Factory	Attawapiskat Kashechewan Fort Albany MoCreebec Moose Factory Moosonee Mushkegowuk New Post (Cochrane) Peawanuck

Table 4.4 (Continued): Locations of Consultation Sessions
Ontario Region

Location	Participating First Nations
Sudbury	Garden River Henvey Island Nipissing Sagamok Sheshegwaning Serpent River Sucker Creek Thessalon Wahnapitae West Bay Whitefish Lake Whitefish River Wikwemikong Kinamnomaudzhewin North Shore Tribal Council Union of Ontario Indians Waabnoog Bemjiwang Tribal Council
Thunder Bay	Michipicoten Pic Mobert Pic River Red Rock Rocky Bay Whitesand
Timmins	Brunswick House Chapleau Cree Matachewan Mattagami Wabun Tribal Council

Table 4.4 (Continued): Locations of Consultation Sessions
Ontario Region

Location	Participating First Nations
Toronto	Alderville Chippewas of Sarnia Chippewas of the Thames Christian Island Curve Lake Georgina Island Golden Lake Kettle & Stony Point Moose Deer Point Munsee-Delaware Rama Union of Ontario Indians

Table 4.5: Locations of Consultation Sessions
Manitoba Region

Location	Participating First Nations
Winnipeg	Barren Lands Berens River Birdtail Sioux Black Sturgeon Bloodvein Brokenhead Buffalo Point Chemawawin Crane River Cross Lake Dakota Plains Ebb and Flow Fisher River Fox Lake Gamblers Garden Hill God's Lake God's River Grand Rapids Jackhead Keeseekoowenin Lake St. Martin Little Black River Little Saskatchewan Long Plain Mathias Colomb Mosakahiken Cree Nelson House Norway House Oak Lake Opaskwayak Cree Oxford House Pauingassi Peguis

Table 4.5 (Continued): Locations of Consultation Sessions
Manitoba Region

Location	Participating First Nations
Winnipeg (Continued)	Pine Creek Poplar River Red Sucker Lake Rolling River Roseau River Sagkeeng Sandy Bay Sapotaweyak Sayisi Dene Sioux Valley St. Theresa Point Swan Lake Valley River War Lake Wasagamack Waywayseecappo Wuskwi Sipihk Cree Nation Tribal Health Centre Dakota Ojibway Tribal Council Fort Alexander Health Centre Island Lake Tribal Council Interlake Reserves Tribal Council Keewatin Tribal Council Long Plain Health Centre Manitoba Keewatinowi Okimakanak Sandy Bay Health Centre Southeast Resource Development Council West Region Tribal Council Winnipeg First Nations Tribal Council

Table 4.6: Locations of Consultation Sessions
Saskatchewan Region

Location	Participating First Nations
Saskatoon	Ahtahkakoop Beardy's Big River Birch Narrow Black Lake Buffalo River Canoe Lake First Nation Carry-the-Kettle Cote Cowessess Cumberland House Denare Beach English River Flying Dust Fond du Lac Gordon James Smith First Nation Kahkewistahow Kawacatoose Key Kinistin Lac La Ronge Indian Band Little Pine Lucky Man Mistawasis Montreal Lake Moosomin Muskeg Lake Muskoday Muskowekwan Nikaneet First Nation Ocean Man Ochapowace One Arrow

Table 4.6 (Continued): Locations of Consultation Sessions
Saskatchewan Region

Location	Participating First Nations
Saskatoon (Continued)	Onion Lake Pasqua Pelican Lake Peter Ballantyne Pheasant Rump Piapot Poundmaker Red Earth Sakimay Saulteaux Shoal Lake Standing Buffalo Star Blanket Sturgeon Lake First Nation Sweetgrass Cree Nation Thunderchild First Nation Wahpeton Dakota Nation Wollaston Lake Waterhen Whitecap Dakota Sioux First Nation Witchekan Lake Yellow Quill

Table 4.7: Locations of Consultation Sessions
Alberta Region

Location	Participating First Nations
1. Calgary	Blood Nation Peigan Sarcee Siksika Stoney
2. Edmonton	None
3. Fort McMurray	Chipewyan Athabasca Cree Fort McKay First Nation Fort McMurray First Nation Mikisew Cree
4. High Level	Driftpile Sturgeon Lake Sucker Creek
5. High Prairie	Dene Tha' Tallcree
6. Peace River	Big Stone Cree Duncan's Band Loon River Band Swan River First Nation
7. St. Paul	None

Table 4.8: Locations of Consultation Sessions
Pacific Region

Location	Participating First Nations
None	None

Table 4.9: Locations of Consultation Sessions
Yukon Region

Location	Participating First Nations
Whitehorse	Car Cross/Tagish Carmacks FN Champagne/Aishihik FN Kluane FN Kwanlin-Dun FN Liard FN Ross River Dene Council Selkirk FN Teslin FN Tron'dek Hwechin FN Vuntut Gwitchin FN White River FN

Table 4.10: Communities Submitting a Written Response

Region	First Nation
Atlantic	Miawpukek Band (Conne River) Union of New Brunswick Indians
Quebec	Micmac: Gesgapegiag Listigauche Mohawk: Akwesasne Kanesatake Kahanawake
Ontario	Alderville First Nation Algonquins of Golden Lake First Nation Attawapiskat First Nation Chippewas of Kettle & Stony Point F.N. Fort Albany First Nation Garden River First Nation Kashechewan Moose Cree First Nation Moosonee Sagamok Anishnawbek First Nation Weenusk First Nation Mushkegowuk Tribal Council
Manitoba	None Received
Saskatchewan	Federation of Saskatchewan Indian Nations
Alberta	Duncan's Band Fort McMurray Band Lesser Slave Lake Regional Indian Council
Pacific	Upper Nicola Indian Band
Yukon	Champagne/Aishihik First Nations Ta'an Kwachan Council

Section Five

The Joint Task Force Recommendations

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Section Five
The Joint Task Force Recommendations

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1. Introduction: The Process

The verbatim transcripts of the suggestions, recommendations and information that were provided by the First Nations[1] community members through the Consultation Process were compiled into a detailed synopsis. This synopsis, together with the full verbatim transcripts, were provided to all members of the Joint Task Force (JTF). The Consultation Process is described fully in Section Four of this Report and the verbatim records are contained in Appendix "H" in Volume Two of this Report.

The members of the JTF met on several occasions in the fall of 1995 to review the recommendations and suggestions from the First Nations. The material was reviewed, organized and compiled in the format of the key program and administrative questions that had been presented to the First Nations during the Consultation Process. These questions are listed in Section Four of the Report and also in the Consultation Workbook which is attached as Appendix "C" of this Report. Recommendations were sought on the following issues:

a. The Future Management Options for NIHB

b. The Core Program Principles

c. The Core Benefits

d. The Eligibility Criteria

e. The Appeals Process

f. Client Identification

g. Contract Negotiations

h. Claims Payment

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[1] The term "First Nation" in the context of this Report also includes the Innu.

The JTF discussed each of these issues in detail, considering the potential impact of the First Nations' recommendations on the NIHB Program. Where possible, a consensus was reached between the Medical Services Branch (MSB) and the Assembly of First Nations (AFN) representatives, but on some issues this was not possible. This Section of the Report reflects the substance of these discussions and highlights the concerns that were raised.

During the course of the Consultation Process, MSB released a document containing a description of five potential options that could be implemented to manage within the constraints imposed by the Envelope Budgetary System. These potential options were to:

a. Prioritize all MSB Programs;

b. Review the levels and types of Benefits provided through the NIHB Program;

c. Limit NIHBs to On-Reserve residents only;

d. Limit NIHBs to On-Reserve residents who were in receipt of Social Assistance;

e. Reconfigure NIHBs into both National and Regional Benefits.

These five potential options were unanimously rejected by the First Nations during the Consultation Process.

2. National Framework Agreement on Health

The JTF considered the comments from the First Nations participants in the Consultation Process regarding their rejection of the five potential options for managing within the "Envelope" system, as described above. There was a general feeling that the issue of "health" must be addressed by the political leadership in a comprehensive, holistic manner.

The concern was often raised during the Consultation Process that health should not be addressed in a fragmented, piecemeal approach. Consequently, although this is outside the specific mandate of the JTF, it is suggested that a National Framework Agreement be developed between the First Nations leadership and the Minister of Health. Such a National Framework should address all aspects relating to the health and well-being of the First Nations and should advance the movement of Health Jurisdiction and control to the First Nations peoples and their governments.

The JTF recognized the importance of a partnership approach to health and considered that the establishment of a National Framework within a reasonable time period was of major importance in the relationship between the First Nations and the federal government.

3. Key NIHB Program Elements

3(a) Future Management Options for the NIHB Program:

The JTF produced a document entitled "Discussion Paper on the Possible Management Options for the NIHB Program" which was provided to participants prior to the Consultation Sessions. This document is attached as Appendix "D" of this Report.

The Discussion Paper listed 12 different possible management options for the NIHB Program. It also described some of the potential advantages and disadvantages with each of the listed options. These twelve options were discussed with the participants during the Consultation Process and they were asked to provide their recommendations on how the NIHB Program should be managed in the future.

A large majority of the First Nations participants clearly stated that they were neither prepared nor mandated to make any recommendations on the future management of the NIHB Program at that time. Many First Nations requested more time for discussions at the community level before they could recommend a future management option.

Many of the First Nations were reluctant to suggest any recommendations on management options until the issue of Treaty Right to Health was resolved.

The majority of the participants at the Consultation Sessions expressed the opinion that no specific management option should be recommended until after the two-year NIHB Pilot Projects were completed and the results were evaluated. It was frequently suggested that further consultations with the First Nations should occur when these results were available, as this would provide some practical experiences upon which to base an informed decision.

First Nations expressed many concerns about making any recommendations for the future management of the NIHB Program. They stated that by making recommendations without a complete understanding of the full implications of their decision they might weaken their position regarding Treaty Rights. They were apprehensive about lessening the federal government's obligations regarding the Fiduciary Responsibilities toward future generations.

This reluctance by many First Nations to select an option was compounded by a recognition that to date there had been little involvement in the management of the NIHB Program by community members. The participants in the Consultation Process identified a need to gain a greater understanding of the complexities of this

major Program. They wished to gain experience in the administrative processes prior to making any recommendations for change.

There was a general concern that the First Nations were experiencing pressures from MSB to accept Transfer of Community Health Services. This was thought to be driven by the intent to remove itself from the direct delivery of services as soon as possible. Although Medical Services stated that transfer will occur at a pace acceptable to First Nations, the fear was expressed that if Transfer was recommended as an option for the NIHB Program, they would be subject to similar pressures.

The options most frequently recommended were:

a. Co-Management;

b. maintaining the Status Quo;

c. management through Contribution Agreement.

These three options were seen to maintain the fiduciary obligations of the Crown, to protect the Treaty Rights and also to ensure the continuation of the NIHB Program for future generations

The Co-Management option was recommended most often. Co-Management was seen as a way for First Nations to gain practical experience in the management and administration of the NIHB Program. At the same time, it would provide the basis for a smooth transition to full transfer for those First Nations communities seeking Transfer at a time of their own choosing.

The JTF discussed the concerns and recommendations expressed by the First Nations. The AFN Chiefs on the JTF strongly supported the suggestions from the First Nations that the two-year Pilot Projects should be completed before any recommendations on future management options for the NIHB Program were made.

The MSB members of the JTF stated that they required additional authorities, such as transfer and the ability to include NIHB in Integrated Community Based Agreements, to meet the current demands of some First Nations.

The AFN Chiefs considered that those First Nations which were interested in the transfer of the NIHB Program had an opportunity to participate in the Pilot Projects. They pointed out to the M.S.B. representatives that a First Nation could also assume the full control of NIHB through the Self-Government process.

The MSB representatives advised that it was necessary to seek the authority for full and complete transfer so that it would be available at the conclusion of the two-year Pilot Projects. A Pilot Project which had successfully tested the Transfer option would thus not be prevented from continuing to operate at the conclusion of the Project.

The AFN Chiefs commented that the Pilot Project Handbook indicates that Projects could be extended by a further year. This third year would logically provide the opportunity for MSB to seek the additional authorities to continue a Project which had successfully tested the Transfer option. They cautioned MSB that the Pilot Projects were intended to test the viability and cost-effectiveness of all the various management options, not only transfer. The AFN Chiefs stated that for MSB to proceed with transfer of the NIHB Program prior to the evaluation of the Pilot Projects was not a good decision.

After considerable debate, the JTF agreed to support the recommendation from the majority of First Nations in the Consultation Process that no authority to transfer the NIHB Program beyond that granted with the NIHB Pilot Projects or through the Self-Government Process should be sought by MSB at this time. In making this recommendation, the JTF acknowledged that the need for additional authorities might be identified during the joint development of the suggested National Framework in order to facilitate its implementation.

The Chiefs in the AFN Caucus recognized that NIHB is a unique program both in the way that it operates and in the way that it has historically been funded. They consider that, in essence, the NIHB Program is a benefits insurance program, which provides a specified list of medical and dental items and services to the eligible clients. As such, the Program expenditures are driven by how many individuals need to access benefits in any given year. The charts and graphs shown in Appendix "E" demonstrate that these costs have varied widely from year to year and from Region to Region.

The JTF Chiefs recognize that if NIHB is transferred to a community **with a fixed, capped budget**, the nature and basis for the Program will have changed. Although strongly supporting the right of the First Nations to control, manage and administer their own programs and services, they caution that the NIHB Program should not be accepted for transfer by a First Nation community without the guarantee of open-ended funding which is driven by need.

The MSB members of the Task Force understand the views expressed by the AFN members. However, the current fiscal situation makes it impossible to continue with the Status Quo in terms of the delivery of NIHB. The introduction of the Envelope

presents another opportunity for the First Nations and MSB to work together to develop and implement new and effective management options, supported by a three-year Envelope of continued budgetary growth. If no new management options are introduced, this may compromise all other programs within the Envelope.

JTF Recommendation #1:

The Joint Task Force recommends that no additional authorities related to the Non-Insured Health Benefits Program should be sought by Medical Services Branch until the NIHB Pilot Projects have been completed and evaluated.

3(b) Program Principles for the NIHB Program

The establishment of Core Program Principles

In the early months of the JTF, the MSB representatives presented the current principles of the NIHB Program to the AFN Task Force members. These are shown at the end of this Section of the Report, in Table 5.1.

The Chiefs representing the AFN on the JTF examined these Principles as tabled by MSB and considered that they conflicted with some of the fundamental beliefs held by the First Nations. The Chiefs recognized the need to seek the advice of the First Nations community members as to what principles they considered to be appropriate for the delivery of the NIHB Program. As an interim measure, they prepared a draft set of principles to demonstrate to MSB that there were some basic differences of opinion on what these principles should be. The AFN Chiefs stated that they did not wish to make any recommendations until they had obtained the opinions of the First Nations' peoples. The draft principles as tabled by the AFN Chiefs are shown in Appendix "C" of this Report. A revised list of principles was adopted by an Assembly of the AFN and adopted as Guiding Principles. These Guiding Principles are included as Table 5.2 at the end of this Section of this Report.

Both sets of principles were discussed with the participants during the Consultation Process. The participants were asked to recommend principles for the NIHB Program. They were also asked if there should be core principles which would be universally applied in the delivery of the NIHB Program, whether it be by MSB or by First Nations.

The First Nations almost unanimously recommended that the NIHB Program operate under Core Principles. There was also almost full agreement that these Core Principles must be followed by both MSB and by any First Nation that chose to either administer or transfer the NIHB Program. The establishment of Core Principles was considered to be an essential element necessary to maintain the full portability and universality of Benefits..

JTF Recommendation #2:

The Joint Task Force recommends that Core Principles be defined at the national level and that they be implemented by all Medical Services Branch Regions and First Nations and Inuit communities and organizations which manage the NIHB Program.

The Treaty Right to Health:

During the Consultation Process the concern over the Treaty Right to Health was constantly expressed. It was stated that the recognition of the Treaty Right to Health was central to any discussion concerning health programs. Some participants stated that this issue must be resolved prior to making any recommendations for the future management of the NIHB Program.

The AFN Guiding Principles for NIHB include the following statement: *"Health is a Treaty and a First Nation Aboriginal Right".* The Chiefs recognized that the JTF did not have a mandate to resolve this issue, but they strongly believe that Health **is** a Treaty and Aboriginal Right and that this should be a Core Principle for the NIHB Program.

There was unanimous agreement from all members of the JTF that this issue was of major importance in the relationship between First Nations and the federal government. Consequently, at a meeting of the Joint Task Force on December 1,1994 the following motion was unanimously passed:

WHEREAS the AFN/MSB Joint Task Force on the Future Management of Non-Insured Health Benefits recognizes and acknowledges that the issue of "Health as a Treaty Right" must be resolved as a basis for future service delivery of health programs, and;

WHEREAS the AFN/MSB Joint Task Force on the Future Management of Non-Insured Health Benefits supports the process that the issue of "Health as a Treaty Right" be addressed at a more senior political level, and;

WHEREAS the Prime Minister of Canada has committed to addressing the issue of Treaties through the Liberal Party Red Book;

THEREFORE BE IT RESOLVED that the AFN/MSB Joint Task Force on the Future Management of Non-Insured Health Benefits agrees that the issue of "Health as a Treaty Right" be forwarded to the National Chief, Assembly of First Nations and to the Minister of Health Canada for immediate resolution."

Moved: Chief Nora Bothwell
Seconded: Al Garman

This Resolution was forwarded to the Deputy Minister, Health Canada, and the National Chief, Assembly of First Nations. The Minister of Health has publicly stated that the Department of Indian Affairs and Northern Development has the lead role in resolving the issue of Treaty Rights. The Minister is fully supportive and is willing to participate in this process.

JTF Recommendation #3:

The Joint Task Force recommends that the Principle of Health as a Treaty and/or Aboriginal and/or First Nations Right be resolved at the most senior political level pursuant to the December 1, 1994 Joint Task Force Resolution.

On and Off-Reserve Membership:

The First Nations unanimously expressed the opinion that Non-Insured Health Benefits continue to be provided to eligible On and Off-Reserve individuals regardless of their income level.

Many First Nations also stated that Non-Insured Health Benefits should be provided to First Nations individuals[2] regardless of their place of residence On or Off-Reserve

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[2] Throughout these Joint Task Force Recommendations and elsewhere in this Report the term "First Nations individuals" shall be taken to mean "Recognized Inuit, Innu and Registered Indians".

or their country of residence.

JTF Recommendation #4:

The Joint Task Force recommends that Non-Insured Health Benefits continue to be provided to the On and Off-Reserve First Nations individuals of Canada.

JTF Recommendation #5:

The Joint Task Force recommends that Non-Insured Health Benefits continue to be provided without regard to the financial status of the First Nations individuals of Canada.

Residence in Canada:

The First Nations stated that many traditional and Reserve lands were arbitrarily divided by the border between Canada and the United States of America. The Chiefs representing the AFN on the JTF supported the recommendations from these First Nations that Non-Insured Health Benefits should be provided regardless of country of residence.

MSB representatives indicated that currently Non-Insured Health Benefits are only available to Registered Indians, recognized Inuit and Innu who reside in Canada. Supplementary health insurance coverage is purchased as a matter of policy for bona fide students and migrant workers who are temporarily resident outside Canada. The MSB representatives stressed that under the Envelope system of budgetary control there was insufficient funding to permit coverage to be extended to individuals who were non-resident in Canada.

There was no consensus by the Joint Task Force regarding the recommendations of the First Nations that Non-Insured Health Benefits should be available to those First Nations individuals who reside outside Canada.

The Payer of Last Resort:

The current MSB Principles state that the Crown *"is the Payer of Last Resort"*. This Principle requires that any other benefit coverage, such as private insurance, employment health benefit coverage or car insurance in the case of injuries resulting from motor vehicle accidents, should be accessed first.

This Principle of *"Payer of Last Resort"* was rejected by a substantial majority of the First Nations during the Consultation Process. One of the Draft Principles tabled by the Chiefs representing the AFN states *"The Crown is the primary provider of all health services including NIHB"*, and this was repeatedly endorsed by the First Nations. A small number of participants indicated that they would not object to the MSB principle if it was a seamless, invisible process and they did not receive any administrative or payment hassle. These participants stated that MSB should provide the item (if it is on the Benefit List) and should then recover the costs from the other payment source. It was stressed that if this were to be the case, the process should be invisible to the First Nation individual concerned.

This Principle was discussed at length by the JTF. The AFN representatives strongly supported the position of the First Nations, stating that the concept of the Crown as the Payer of First Resort flows from the Treaty Right to Health.

The MSB representatives on the JTF were concerned that if the NIHB Program was identified as the primary source of benefits it would become impossible to recover any costs from other insurers. This would result in a significant escalation in the total cost of Non-Insured Health Benefits. This increase in costs, under the Envelope system of budgetary control, would result in less money being available to provide other benefits.

After considerable discussion, the AFN Joint Task Force members reluctantly agreed to the compromise solution as suggested by some of the participants at the Consultation Sessions. This compromise would make MSB the Facilitator of First Resort.

Barriers to Accessibility:

During the course of the Consultation Process, participants complained about the increasingly frequent occurrence of dentists requiring a cash deposit when booking a dental procedure that required an anaesthetic. The participants acknowledged that the deposit was returned when the individual attended the appointment.

Several of the participants stated that as they were unable to pay the deposit they were therefore unable to access this type of treatment. One of the unique features of the NIHB Program identified by MSB is the fact that no payment is required at the point of service. These participants requested that MSB assume the responsibility for paying any necessary deposits so that individuals would not be denied access to a service which was otherwise available through the NIHB Program.

This subject was the focus of considerable discussion by the JTF. The AFN Chiefs stated that they considered that this was a simple administrative problem which could easily be rectified. The MSB representatives, however, stated that the issue was not that simple. The policy of MSB was to pay for services which were received, not to pay for services which were not received which would be the case if an individual failed to attend the scheduled appointment.

The position adopted by the MSB representatives was that they would either assist the individual in locating a practitioner who did not require a deposit or they would intervene with the practitioner, providing that this matter was brought to their attention.

The AFN Chiefs considered that this was neither a satisfactory nor a practical resolution for a problem which was increasingly restricting access to services. They expressed concern that at times the First Nations administration was forced to provide these deposits so that members could access necessary services.

Another concern voiced by participants was that some physicians were requesting payment of a professional fee before renewing a prescription. This issue was also creating a barrier to service accessibility, as was the increasing requirement to pay a deposit, as described above.

After discussion, the JTF agreed that any barriers which reduced access to the NIHB Program should be removed. The MSB representatives acknowledged the existence of these problems and agreed to work to resolve these issues "in due course".

JTF Recommendation #6:

The Joint Task Force recommends that:

a. Non-Insured Health Benefits must be provided when and as needed;

b. Medical Services Branch must ensure that no barriers impede accessibility to Non-Insured Health Benefits;

c. ***Medical Services Branch should immediately develop and implement a process to coordinate benefits which will allow the benefit or service to be provided without inconveniencing or adversely affecting the beneficiary.***

d. ***Eligible First Nations individuals must declare any other benefit coverage to facilitate the delivery of benefits or services by either Medical Services Branch or the First Nation Organization[3] responsible for the management of the NIHB Program.***

First Nation Involvement:

The Draft AFN Principles, which were ratified at an All Chiefs Assembly, state *"Health Services should not be changed without the agreement of First Nations".*

This position was consistently endorsed by the participants at the Consultation Sessions. First Nations strongly stated that health services should not be changed without their agreement. They wish to be consulted on program issues that impact on their health and well-being. They also insist on having an active role in the decision-making process. They stated that there must be no more unilateral decisions made by MSB.

The need for a national joint decision-making process was unanimously accepted by the members of the JTF. A discussion took place on how this recommendation should be implemented. There was a concern that representatives could be arbitrarily appointed to a decision-making body without the democratic support of the First Nations or Inuit communities. It was agreed that representatives of the Assembly of First Nations, the Inuit Tapirisat and by the Innu and Non-Affiliated First Nations must be selected and appointed to be part of the decision-making process.

It was further agreed that these appointments must be endorsed at General Assemblies or like gatherings.

JTF Recommendation #7:

The Joint Task Force recommends:

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[3] The term "First Nation Organization" shall be taken to also include any comparable Inuit and Innu Organization.

The First Nations considered this brief presentation not to be a proper Orientation but only an overview of the NIHB Program.

ii. Consultation:

One Consultation Session was organized and coordinated by the Health and Social Services Commission of Quebec on behalf of all the First Nations and Innu in the Quebec Region. Many of the participants at the Consultation Session had not attended the original Information/Orientation Session.

Those participants who had attended the original Orientation/Information Session commented that the information presented at the Consultation Session was more detailed and comprehensive than that provided at the Information/Orientation Session. The participants attending the Consultation Session therefore requested by Band Council Resolution that a second Consultation Session be organized so that the community recommendations for the NIHB Program could be presented.

Although a second Consultation Session was not provided, the Regional Director extended a verbal invitation to work with individual First Nations on any NIHB issues. As a result, very few recommendations were received from the First Nations of Quebec.

c. Ontario Region:

i. Orientation:

The Region carried out seven three-day Information Sessions on a variety of MSB Program issues, including the NIHB Program. The JTF Consultation Team provided the Information/Orientation Sessions as a part of this Ontario Region process.

Initially, the Region decided that both the Information/Orientation Session and the Consultation Session would be combined into one meeting. The AFN Caucus of the JTF objected to this approach by the Ontario Region, as it did not allow time for community discussions. This Regional process was also not well accepted by the First Nations of Ontario and the full JTF Consultation Process was eventually adopted in Ontario Region.

ii. Consultation:

The Ontario Region left the organization of the Consultation Sessions to the First Nations. The First Nations organizations were advised to contact the JTF Consultation Team themselves if they wished to participate in the Consultation Process.

Consultation Sessions were held with all the First Nations groups, with the exception of the Association of Iroquois and Allied Indians (AIAI). The Consultation Team contacted AIAI, which declined to participate in the process.

d. Manitoba Region:

i. Orientation:

The Region delegated the coordination of the Information/Orientation Sessions to the Assembly of Manitoba Chiefs (AMC). The AMC organized one, large Information/Orientation Session to which all of the First Nations in Manitoba were invited.

ii. Consultation:

The AMC coordinated one Consultation Session for all of the First Nations in Manitoba, which was held in Winnipeg.

e. Saskatchewan:

i. Orientation:

The Region coordinated seven individual Information/Orientation Sessions with the various Tribal Councils in Saskatchewan. A representative from each of the Tribal Council member communities attended these Sessions.

ii. Consultation:

All First Nations in Saskatchewan were invited to attend a Health Workshop organized by the Federation of Saskatchewan Indian Nations (FSIN). The Consultation Team was allocated time at this Health Workshop to review the information that was presented at the Information/Orientation Sessions. The participants then broke into working groups.

The FSIN modified the Consultation Questions that were presented by the Consultation Team and the participants in the working groups focused on these revised questions. The FSIN submitted a written response on behalf of all the First Nations in Saskatchewan. This response is included in Volume 2, Appendix "H" of this Report.

f. Alberta Region:

i. Orientation:

Individual Information/Orientation Sessions were held for each of the three Treaty areas. Three Sessions were held, one each for Treaty 6, Treaty 7 and Treaty 8.

ii. Consultation:

The Consultation Sessions were organized by the Zone Directors for each Treaty Area. Four Consultation Sessions were held for the Treaty 8 First Nations, two Sessions were scheduled for Treaty 6 and one Session was held for Treaty 7.

The Chiefs of the Treaty 6 First Nations declined to participate in the Consultation Process.

g. Pacific Region:

i. Orientation:

The Region organized five three-day "pre-consultation sessions" with the Health Committee of the First Nations Summit. These pre-consultation sessions addressed a variety of MSB Program issues, including the NIHB Program.

The Health Committee of the First Nations Summit chose not to allocate the time necessary for the full NIHB Information/Orientation Session. The Consultation Team consequently was required to substantially abbreviate the presentations to fit the time allocated. In one instance, the Consultation Team was provided with only a 20 minute time slot.

Although this process did not follow the JTF format, the Consultation Team was able to provide the information packages to those who attended the sessions.

ii. Consultation:

Neither the Pacific Region nor the Health Committee of the First Nations Summit organized any Consultation Sessions. The JTF Report contains recommendations from only one of the Pacific Region First Nations.

The Region defined a local consultation process which would take place in three stages: pre-consultation, bilateral consultation and a Regional meeting. At these pre-consultation meetings, the participants were advised that further consultation would occur over the following months, at the specific invitation of the communities. The pre-consultation process was completed in March 1995.

Following the pre-consultation meetings, Zone Directors and other staff met with Bands and Tribal Councils in the course of their day-to-day operational duties. During these meetings, the Pacific Region reported that it was apparent that the First Nations in the Region had little interest in discussing the JTF issues on the NIHB Program.

h. Yukon Region:

i. Orientation:

The Region coordinated an Information/Orientation Session with the Council of Yukon Indians (CYI). Representatives from each community attended the Session.

ii. Consultation:

The Region and the CYI coordinated a Consultation Session in Whitehorse which was attended by representatives from each community.

8. First Nations' Comments on the Consultation Process

Many of the First Nations participants who attended the Consultation Sessions expressed the need for additional time in which to continue the consultation process with their community members. The question "what's the rush?" was frequently asked. The opinion was expressed that the responsibility for continuing the consultation at the community level was a difficult job after only a short Orientation Session.

Concern was expressed that any recommendations which were made would have a far-reaching effect on the future of the NIHB Program regarding future generations. Many participants expressed the need for MSB's assistance at the community level and requested that the Information/Orientation Session be provided at the community level.

First Nations have very clearly expressed the view that Consultation is an ongoing and important process. It was stated that an adequate time frame should be allocated without the imposition of any external pressures such as an arbitrary deadline for completion of the process.

Many participants, including Chiefs, Councilors and Elders, stated that the JTF should not make any recommendations on the Future Management Options for the NIHB Program until the results of the Pilot Projects were available.

9. Joint Task Force Observations on the Consultation Process

The JTF identified a number of issues which may be of interest for those who carry out consultation with First Nations in the future.

When planning the consultation process, the JTF envisaged that the individual attending the Orientation/Information Session would return for the Consultation Session. In the majority of cases, the individuals attending the Consultation Session did not include the individual who originally attended the Orientation/Information Session. In addition, in many cases the individuals attending the Consultation Session were not familiar with the NIHB material and were not aware that an Orientation/Information Session had taken place.

Many individuals also indicated that they did not come to the Consultation Session with a mandate to provide recommendations or suggestions on the NIHB Program on behalf of their community and therefore felt uncomfortable at being asked to make suggestions which they felt would affect their community.

Table 4.1: Locations of Information/Orientation Sessions

Region	Location	Tribal Council Member Nations
Atlantic	Fredericton Halifax Northwest River Sheshashit	Union of New Brunswick Indians Assembly of Nova Scotia Chiefs Labrador Inuit Health Commission Labrador Innu Health Commission
Quebec	Montreal	Quebec First Nations
Ontario	Fort Francis London Sudbury Thunder Bay Timmins Toronto Toronto	Treaty 3 First Nations Association of Iroquois & Allied Indians Union of Ontario Indians Nishnawbe-Aski Nation Nishnawbe-Aski Nation Union of Ontario Indians Independent First Nations
Manitoba	Dakota Tipi	Assembly of Manitoba Chiefs
Saskatchewan	Fort Qu'Appelle La Ronge Manitou Beach North Battleford North Battleford Yorkton Saskatoon	Touchwood File Hills Tribal Council Prince Albert Grand Council Saskatoon Tribal Council Battleford Tribal Council Confederation of Tribal Nations Yorkton Tribal Council Agency Chiefs
Alberta	Calgary Edmonton Edmonton	Treaty 7 First Nations Treaty 6 First Nations Treaty 8 First Nations
Pacific	Chilliwack Kamloops Port Hardy Prince George Terrace	South Mainland Zone First Nations South Mainland Zone First Nations Vancouver Island Zone First Nations North East Zone First Nations North West Zone First Nations
Yukon	Whitehorse	Council of Yukon Indians

Table 4.2: Locations of Consultation Sessions
Atlantic Region

Location	Participating First Nations
Halifax	Acadia Chapel Island Eskasoni Schubenacadie Membertou Wagmatcook Waycobah
St. Basille	Union of New Brunswick Indians
Sheshatshit	Labrador Innu Health Commission

Table 4.3: Locations of Consultation Sessions
Quebec Region

Location	Participating First Nations
Montreal	Akwesasne Betsiamites Eagle Village Gesgapegiag Kanesatake Khanawake Kitcisakik La Romaine Lac Simon Listugus Long Point Manouane Mashteuiatsh Micmacs de Gaspe Mingan Natashquan Obedjiwan Odanak Pikogan Schefferville (Matimekosh) St. Augustin Timiskaming Uashat Mak Mani-u-Tenam (Sept-Iles) Viger (Malecites) Wendake Weymontachie Wolinack Algonquin Tribal Council Atikamekw Sipi (conseil tribal) Mamit Innuat - Mingan (conseil tribal) Waskaganish (observateur)

Table 4.4: Locations of Consultation Sessions
Ontario Region

Location	Participating First Nations
Fort Francis	Big Grassy Big Island Eagle Lake Iskutewiskaygun #39 Lac La Croix Lac Seul Nicickousemenecaning Northwest Angle #33 Northwest Angle #37 Onegaming Rainy River Rat Portage Seine River Stanjikoming Wabaseemoong Wabauskang Wabigoon Whitefish
Moose Factory	Attawapiskat Kashechewan Fort Albany MoCreebec Moose Factory Moosonee Mushkegowuk New Post (Cochrane) Peawanuck

Table 4.4 (Continued): Locations of Consultation Sessions
Ontario Region

Location	Participating First Nations
Sudbury	Garden River Henvey Island Nipissing Sagamok Sheshegwaning Serpent River Sucker Creek Thessalon Wahnapitae West Bay Whitefish Lake Whitefish River Wikwemikong Kinamnomaudzhewin North Shore Tribal Council Union of Ontario Indians Waabnoog Bemjiwang Tribal Council
Thunder Bay	Michipicoten Pic Mobert Pic River Red Rock Rocky Bay Whitesand
Timmins	Brunswick House Chapleau Cree Matachewan Mattagami Wabun Tribal Council

Table 4.4 (Continued): Locations of Consultation Sessions
Ontario Region

Location	Participating First Nations
Toronto	Alderville Chippewas of Sarnia Chippewas of the Thames Christian Island Curve Lake Georgina Island Golden Lake Kettle & Stony Point Moose Deer Point Munsee-Delaware Rama Union of Ontario Indians

Table 4.5: Locations of Consultation Sessions
Manitoba Region

Location	Participating First Nations
Winnipeg	Barren Lands Berens River Birdtail Sioux Black Sturgeon Bloodvein Brokenhead Buffalo Point Chemawawin Crane River Cross Lake Dakota Plains Ebb and Flow Fisher River Fox Lake Gamblers Garden Hill God's Lake God's River Grand Rapids Jackhead Keeseekoowenin Lake St. Martin Little Black River Little Saskatchewan Long Plain Mathias Colomb Mosakahiken Cree Nelson House Norway House Oak Lake Opaskwayak Cree Oxford House Pauingassi Peguis

Table 4.5 (Continued): Locations of Consultation Sessions
Manitoba Region

Location	Participating First Nations
Winnipeg (Continued)	Pine Creek Poplar River Red Sucker Lake Rolling River Roseau River Sagkeeng Sandy Bay Sapotaweyak Sayisi Dene Sioux Valley St. Theresa Point Swan Lake Valley River War Lake Wasagamack Waywayseecappo Wuskwi Sipihk Cree Nation Tribal Health Centre Dakota Ojibway Tribal Council Fort Alexander Health Centre Island Lake Tribal Council Interlake Reserves Tribal Council Keewatin Tribal Council Long Plain Health Centre Manitoba Keewatinowi Okimakanak Sandy Bay Health Centre Southeast Resource Development Council West Region Tribal Council Winnipeg First Nations Tribal Council

Table 4.6: Locations of Consultation Sessions
Saskatchewan Region

Location	Participating First Nations
Saskatoon	Ahtahkakoop Beardy's Big River Birch Narrow Black Lake Buffalo River Canoe Lake First Nation Carry-the-Kettle Cote Cowessess Cumberland House Denare Beach English River Flying Dust Fond du Lac Gordon James Smith First Nation Kahkewistahow Kawacatoose Key Kinistin Lac La Ronge Indian Band Little Pine Lucky Man Mistawasis Montreal Lake Moosomin Muskeg Lake Muskoday Muskowekwan Nikaneet First Nation Ocean Man Ochapowace One Arrow

Table 4.6 (Continued): Locations of Consultation Sessions
Saskatchewan Region

Location	Participating First Nations
Saskatoon (Continued)	Onion Lake Pasqua Pelican Lake Peter Ballantyne Pheasant Rump Piapot Poundmaker Red Earth Sakimay Saulteaux Shoal Lake Standing Buffalo Star Blanket Sturgeon Lake First Nation Sweetgrass Cree Nation Thunderchild First Nation Wahpeton Dakota Nation Wollaston Lake Waterhen Whitecap Dakota Sioux First Nation Witchekan Lake Yellow Quill

Table 4.7: Locations of Consultation Sessions
Alberta Region

Location	Participating First Nations
1. Calgary	Blood Nation Peigan Sarcee Siksika Stoney
2. Edmonton	None
3. Fort McMurray	Chipewyan Athabasca Cree Fort McKay First Nation Fort McMurray First Nation Mikisew Cree
4. High Level	Driftpile Sturgeon Lake Sucker Creek
5. High Prairie	Dene Tha' Tallcree
6. Peace River	Big Stone Cree Duncan's Band Loon River Band Swan River First Nation
7. St. Paul	None

Table 4.8: Locations of Consultation Sessions
Pacific Region

Location	Participating First Nations
None	None

Table 4.9: Locations of Consultation Sessions
Yukon Region

Location	Participating First Nations
Whitehorse	Car Cross/Tagish Carmacks FN Champagne/Aishihik FN Kluane FN Kwanlin-Dun FN Liard FN Ross River Dene Council Selkirk FN Teslin FN Tron'dek Hwechin FN Vuntut Gwitchin FN White River FN

Table 4.10: Communities Submitting a Written Response

Region	First Nation
Atlantic	Miawpukek Band (Conne River) Union of New Brunswick Indians
Quebec	Micmac: Gesgapegiag Listigauche Mohawk: Akwesasne Kanesatake Kahanawake
Ontario	Alderville First Nation Algonquins of Golden Lake First Nation Attawapiskat First Nation Chippewas of Kettle & Stony Point F.N. Fort Albany First Nation Garden River First Nation Kashechewan Moose Cree First Nation Moosonee Sagamok Anishnawbek First Nation Weenusk First Nation Mushkegowuk Tribal Council
Manitoba	None Received
Saskatchewan	Federation of Saskatchewan Indian Nations
Alberta	Duncan's Band Fort McMurray Band Lesser Slave Lake Regional Indian Council
Pacific	Upper Nicola Indian Band
Yukon	Champagne/Aishihik First Nations Ta'an Kwachan Council

Section Five

The Joint Task Force Recommendations

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Section Five
The Joint Task Force Recommendations

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1. Introduction: The Process

The verbatim transcripts of the suggestions, recommendations and information that were provided by the First Nations[1] community members through the Consultation Process were compiled into a detailed synopsis. This synopsis, together with the full verbatim transcripts, were provided to all members of the Joint Task Force (JTF). The Consultation Process is described fully in Section Four of this Report and the verbatim records are contained in Appendix "H" in Volume Two of this Report.

The members of the JTF met on several occasions in the fall of 1995 to review the recommendations and suggestions from the First Nations. The material was reviewed, organized and compiled in the format of the key program and administrative questions that had been presented to the First Nations during the Consultation Process. These questions are listed in Section Four of the Report and also in the Consultation Workbook which is attached as Appendix "C" of this Report. Recommendations were sought on the following issues:

a. The Future Management Options for NIHB

b. The Core Program Principles

c. The Core Benefits

d. The Eligibility Criteria

e. The Appeals Process

f. Client Identification

g. Contract Negotiations

h. Claims Payment

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[1] The term "First Nation" in the context of this Report also includes the Innu.

The JTF discussed each of these issues in detail, considering the potential impact of the First Nations' recommendations on the NIHB Program. Where possible, a consensus was reached between the Medical Services Branch (MSB) and the Assembly of First Nations (AFN) representatives, but on some issues this was not possible. This Section of the Report reflects the substance of these discussions and highlights the concerns that were raised.

During the course of the Consultation Process, MSB released a document containing a description of five potential options that could be implemented to manage within the constraints imposed by the Envelope Budgetary System. These potential options were to:

a. Prioritize all MSB Programs;

b. Review the levels and types of Benefits provided through the NIHB Program;

c. Limit NIHBs to On-Reserve residents only;

d. Limit NIHBs to On-Reserve residents who were in receipt of Social Assistance;

e. Reconfigure NIHBs into both National and Regional Benefits.

These five potential options were unanimously rejected by the First Nations during the Consultation Process.

2. National Framework Agreement on Health

The JTF considered the comments from the First Nations participants in the Consultation Process regarding their rejection of the five potential options for managing within the "Envelope" system, as described above. There was a general feeling that the issue of "health" must be addressed by the political leadership in a comprehensive, holistic manner.

The concern was often raised during the Consultation Process that health should not be addressed in a fragmented, piecemeal approach. Consequently, although this is outside the specific mandate of the JTF, it is suggested that a National Framework Agreement be developed between the First Nations leadership and the Minister of Health. Such a National Framework should address all aspects relating to the health and well-being of the First Nations and should advance the movement of Health Jurisdiction and control to the First Nations peoples and their governments.

The JTF recognized the importance of a partnership approach to health and considered that the establishment of a National Framework within a reasonable time period was of major importance in the relationship between the First Nations and the federal government.

3. Key NIHB Program Elements

3(a) Future Management Options for the NIHB Program:

The JTF produced a document entitled "Discussion Paper on the Possible Management Options for the NIHB Program" which was provided to participants prior to the Consultation Sessions. This document is attached as Appendix "D" of this Report.

The Discussion Paper listed 12 different possible management options for the NIHB Program. It also described some of the potential advantages and disadvantages with each of the listed options. These twelve options were discussed with the participants during the Consultation Process and they were asked to provide their recommendations on how the NIHB Program should be managed in the future.

A large majority of the First Nations participants clearly stated that they were neither prepared nor mandated to make any recommendations on the future management of the NIHB Program at that time. Many First Nations requested more time for discussions at the community level before they could recommend a future management option.

Many of the First Nations were reluctant to suggest any recommendations on management options until the issue of Treaty Right to Health was resolved.

The majority of the participants at the Consultation Sessions expressed the opinion that no specific management option should be recommended until after the two-year NIHB Pilot Projects were completed and the results were evaluated. It was frequently suggested that further consultations with the First Nations should occur when these results were available, as this would provide some practical experiences upon which to base an informed decision.

First Nations expressed many concerns about making any recommendations for the future management of the NIHB Program. They stated that by making recommendations without a complete understanding of the full implications of their decision they might weaken their position regarding Treaty Rights. They were apprehensive about lessening the federal government's obligations regarding the Fiduciary Responsibilities toward future generations.

This reluctance by many First Nations to select an option was compounded by a recognition that to date there had been little involvement in the management of the NIHB Program by community members. The participants in the Consultation Process identified a need to gain a greater understanding of the complexities of this

major Program. They wished to gain experience in the administrative processes prior to making any recommendations for change.

There was a general concern that the First Nations were experiencing pressures from MSB to accept Transfer of Community Health Services. This was thought to be driven by the intent to remove itself from the direct delivery of services as soon as possible. Although Medical Services stated that transfer will occur at a pace acceptable to First Nations, the fear was expressed that if Transfer was recommended as an option for the NIHB Program, they would be subject to similar pressures.

The options most frequently recommended were:

a. Co-Management;

b. maintaining the Status Quo;

c. management through Contribution Agreement.

These three options were seen to maintain the fiduciary obligations of the Crown, to protect the Treaty Rights and also to ensure the continuation of the NIHB Program for future generations

The Co-Management option was recommended most often. Co-Management was seen as a way for First Nations to gain practical experience in the management and administration of the NIHB Program. At the same time, it would provide the basis for a smooth transition to full transfer for those First Nations communities seeking Transfer at a time of their own choosing.

The JTF discussed the concerns and recommendations expressed by the First Nations. The AFN Chiefs on the JTF strongly supported the suggestions from the First Nations that the two-year Pilot Projects should be completed before any recommendations on future management options for the NIHB Program were made.

The MSB members of the JTF stated that they required additional authorities, such as transfer and the ability to include NIHB in Integrated Community Based Agreements, to meet the current demands of some First Nations.

The AFN Chiefs considered that those First Nations which were interested in the transfer of the NIHB Program had an opportunity to participate in the Pilot Projects. They pointed out to the M.S.B. representatives that a First Nation could also assume the full control of NIHB through the Self-Government process.

The MSB representatives advised that it was necessary to seek the authority for full and complete transfer so that it would be available at the conclusion of the two-year Pilot Projects. A Pilot Project which had successfully tested the Transfer option would thus not be prevented from continuing to operate at the conclusion of the Project.

The AFN Chiefs commented that the Pilot Project Handbook indicates that Projects could be extended by a further year. This third year would logically provide the opportunity for MSB to seek the additional authorities to continue a Project which had successfully tested the Transfer option. They cautioned MSB that the Pilot Projects were intended to test the viability and cost-effectiveness of all the various management options, not only transfer. The AFN Chiefs stated that for MSB to proceed with transfer of the NIHB Program prior to the evaluation of the Pilot Projects was not a good decision.

After considerable debate, the JTF agreed to support the recommendation from the majority of First Nations in the Consultation Process that no authority to transfer the NIHB Program beyond that granted with the NIHB Pilot Projects or through the Self-Government Process should be sought by MSB at this time. In making this recommendation, the JTF acknowledged that the need for additional authorities might be identified during the joint development of the suggested National Framework in order to facilitate its implementation.

The Chiefs in the AFN Caucus recognized that NIHB is a unique program both in the way that it operates and in the way that it has historically been funded. They consider that, in essence, the NIHB Program is a benefits insurance program, which provides a specified list of medical and dental items and services to the eligible clients. As such, the Program expenditures are driven by how many individuals need to access benefits in any given year. The charts and graphs shown in Appendix "E" demonstrate that these costs have varied widely from year to year and from Region to Region.

The JTF Chiefs recognize that if NIHB is transferred to a community **with a fixed, capped budget**, the nature and basis for the Program will have changed. Although strongly supporting the right of the First Nations to control, manage and administer their own programs and services, they caution that the NIHB Program should not be accepted for transfer by a First Nation community without the guarantee of open-ended funding which is driven by need.

The MSB members of the Task Force understand the views expressed by the AFN members. However, the current fiscal situation makes it impossible to continue with the Status Quo in terms of the delivery of NIHB. The introduction of the Envelope

presents another opportunity for the First Nations and MSB to work together to develop and implement new and effective management options, supported by a three-year Envelope of continued budgetary growth. If no new management options are introduced, this may compromise all other programs within the Envelope.

JTF Recommendation #1:

The Joint Task Force recommends that no additional authorities related to the Non-Insured Health Benefits Program should be sought by Medical Services Branch until the NIHB Pilot Projects have been completed and evaluated.

3(b) Program Principles for the NIHB Program

The establishment of Core Program Principles

In the early months of the JTF, the MSB representatives presented the current principles of the NIHB Program to the AFN Task Force members. These are shown at the end of this Section of the Report, in Table 5.1.

The Chiefs representing the AFN on the JTF examined these Principles as tabled by MSB and considered that they conflicted with some of the fundamental beliefs held by the First Nations. The Chiefs recognized the need to seek the advice of the First Nations community members as to what principles they considered to be appropriate for the delivery of the NIHB Program. As an interim measure, they prepared a draft set of principles to demonstrate to MSB that there were some basic differences of opinion on what these principles should be. The AFN Chiefs stated that they did not wish to make any recommendations until they had obtained the opinions of the First Nations' peoples. The draft principles as tabled by the AFN Chiefs are shown in Appendix "C" of this Report. A revised list of principles was adopted by an Assembly of the AFN and adopted as Guiding Principles. These Guiding Principles are included as Table 5.2 at the end of this Section of this Report.

Both sets of principles were discussed with the participants during the Consultation Process. The participants were asked to recommend principles for the NIHB Program. They were also asked if there should be core principles which would be universally applied in the delivery of the NIHB Program, whether it be by MSB or by First Nations.

The First Nations almost unanimously recommended that the NIHB Program operate under Core Principles. There was also almost full agreement that these Core Principles must be followed by both MSB and by any First Nation that chose to either administer or transfer the NIHB Program. The establishment of Core Principles was considered to be an essential element necessary to maintain the full portability and universality of Benefits.

JTF Recommendation #2:

The Joint Task Force recommends that Core Principles be defined at the national level and that they be implemented by all Medical Services Branch Regions and First Nations and Inuit communities and organizations which manage the NIHB Program.

The Treaty Right to Health:

During the Consultation Process the concern over the Treaty Right to Health was constantly expressed. It was stated that the recognition of the Treaty Right to Health was central to any discussion concerning health programs. Some participants stated that this issue must be resolved prior to making any recommendations for the future management of the NIHB Program.

The AFN Guiding Principles for NIHB include the following statement: *"Health is a Treaty and a First Nation Aboriginal Right".* The Chiefs recognized that the JTF did not have a mandate to resolve this issue, but they strongly believe that Health **is** a Treaty and Aboriginal Right and that this should be a Core Principle for the NIHB Program.

There was unanimous agreement from all members of the JTF that this issue was of major importance in the relationship between First Nations and the federal government. Consequently, at a meeting of the Joint Task Force on December 1,1994 the following motion was unanimously passed:

WHEREAS the AFN/MSB Joint Task Force on the Future Management of Non-Insured Health Benefits recognizes and acknowledges that the issue of "Health as a Treaty Right" must be resolved as a basis for future service delivery of health programs, and;

WHEREAS the AFN/MSB Joint Task Force on the Future Management of Non-Insured Health Benefits supports the process that the issue of "Health as a Treaty Right" be addressed at a more senior political level, and;

WHEREAS the Prime Minister of Canada has committed to addressing the issue of Treaties through the Liberal Party Red Book;

THEREFORE BE IT RESOLVED that the AFN/MSB Joint Task Force on the Future Management of Non-Insured Health Benefits agrees that the issue of "Health as a Treaty Right" be forwarded to the National Chief, Assembly of First Nations and to the Minister of Health Canada for immediate resolution."

Moved: Chief Nora Bothwell
Seconded: Al Garman

This Resolution was forwarded to the Deputy Minister, Health Canada, and the National Chief, Assembly of First Nations. The Minister of Health has publicly stated that the Department of Indian Affairs and Northern Development has the lead role in resolving the issue of Treaty Rights. The Minister is fully supportive and is willing to participate in this process.

JTF Recommendation #3:

The Joint Task Force recommends that the Principle of Health as a Treaty and/or Aboriginal and/or First Nations Right be resolved at the most senior political level pursuant to the December 1, 1994 Joint Task Force Resolution.

On and Off-Reserve Membership:

The First Nations unanimously expressed the opinion that Non-Insured Health Benefits continue to be provided to eligible On and Off-Reserve individuals regardless of their income level.

Many First Nations also stated that Non-Insured Health Benefits should be provided to First Nations individuals[2] regardless of their place of residence On or Off-Reserve

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[2] Throughout these Joint Task Force Recommendations and elsewhere in this Report the term "First Nations individuals" shall be taken to mean "Recognized Inuit, Innu and Registered Indians".

or their country of residence.

JTF Recommendation #4:

The Joint Task Force recommends that Non-Insured Health Benefits continue to be provided to the On and Off-Reserve First Nations individuals of Canada.

JTF Recommendation #5:

The Joint Task Force recommends that Non-Insured Health Benefits continue to be provided without regard to the financial status of the First Nations individuals of Canada.

Residence in Canada:

The First Nations stated that many traditional and Reserve lands were arbitrarily divided by the border between Canada and the United States of America. The Chiefs representing the AFN on the JTF supported the recommendations from these First Nations that Non-Insured Health Benefits should be provided regardless of country of residence.

MSB representatives indicated that currently Non-Insured Health Benefits are only available to Registered Indians, recognized Inuit and Innu who reside in Canada. Supplementary health insurance coverage is purchased as a matter of policy for bona fide students and migrant workers who are temporarily resident outside Canada. The MSB representatives stressed that under the Envelope system of budgetary control there was insufficient funding to permit coverage to be extended to individuals who were non-resident in Canada.

There was no consensus by the Joint Task Force regarding the recommendations of the First Nations that Non-Insured Health Benefits should be available to those First Nations individuals who reside outside Canada.

The Payer of Last Resort:

The current MSB Principles state that the Crown *"is the Payer of Last Resort"*. This Principle requires that any other benefit coverage, such as private insurance, employment health benefit coverage or car insurance in the case of injuries resulting from motor vehicle accidents, should be accessed first.

This Principle of *"Payer of Last Resort"* was rejected by a substantial majority of the First Nations during the Consultation Process. One of the Draft Principles tabled by the Chiefs representing the AFN states *"The Crown is the primary provider of all health services including NIHB"*, and this was repeatedly endorsed by the First Nations. A small number of participants indicated that they would not object to the MSB principle if it was a seamless, invisible process and they did not receive any administrative or payment hassle. These participants stated that MSB should provide the item (if it is on the Benefit List) and should then recover the costs from the other payment source. It was stressed that if this were to be the case, the process should be invisible to the First Nation individual concerned.

This Principle was discussed at length by the JTF. The AFN representatives strongly supported the position of the First Nations, stating that the concept of the Crown as the Payer of First Resort flows from the Treaty Right to Health.

The MSB representatives on the JTF were concerned that if the NIHB Program was identified as the primary source of benefits it would become impossible to recover any costs from other insurers. This would result in a significant escalation in the total cost of Non-Insured Health Benefits. This increase in costs, under the Envelope system of budgetary control, would result in less money being available to provide other benefits.

After considerable discussion, the AFN Joint Task Force members reluctantly agreed to the compromise solution as suggested by some of the participants at the Consultation Sessions. This compromise would make MSB the Facilitator of First Resort.

Barriers to Accessibility:

During the course of the Consultation Process, participants complained about the increasingly frequent occurrence of dentists requiring a cash deposit when booking a dental procedure that required an anaesthetic. The participants acknowledged that the deposit was returned when the individual attended the appointment.

Several of the participants stated that as they were unable to pay the deposit they were therefore unable to access this type of treatment. One of the unique features of the NIHB Program identified by MSB is the fact that no payment is required at the point of service. These participants requested that MSB assume the responsibility for paying any necessary deposits so that individuals would not be denied access to a service which was otherwise available through the NIHB Program.

This subject was the focus of considerable discussion by the JTF. The AFN Chiefs stated that they considered that this was a simple administrative problem which could easily be rectified. The MSB representatives, however, stated that the issue was not that simple. The policy of MSB was to pay for services which were received, not to pay for services which were not received which would be the case if an individual failed to attend the scheduled appointment.

The position adopted by the MSB representatives was that they would either assist the individual in locating a practitioner who did not require a deposit or they would intervene with the practitioner, providing that this matter was brought to their attention.

The AFN Chiefs considered that this was neither a satisfactory nor a practical resolution for a problem which was increasingly restricting access to services. They expressed concern that at times the First Nations administration was forced to provide these deposits so that members could access necessary services.

Another concern voiced by participants was that some physicians were requesting payment of a professional fee before renewing a prescription. This issue was also creating a barrier to service accessibility, as was the increasing requirement to pay a deposit, as described above.

After discussion, the JTF agreed that any barriers which reduced access to the NIHB Program should be removed. The MSB representatives acknowledged the existence of these problems and agreed to work to resolve these issues "in due course".

JTF Recommendation #6:

The Joint Task Force recommends that:

a. Non-Insured Health Benefits must be provided when and as needed;

b. Medical Services Branch must ensure that no barriers impede accessibility to Non-Insured Health Benefits;

c. ***Medical Services Branch should immediately develop and implement a process to coordinate benefits which will allow the benefit or service to be provided without inconveniencing or adversely affecting the beneficiary.***

d. ***Eligible First Nations individuals must declare any other benefit coverage to facilitate the delivery of benefits or services by either Medical Services Branch or the First Nation Organization[3] responsible for the management of the NIHB Program.***

First Nation Involvement:

The Draft AFN Principles, which were ratified at an All Chiefs Assembly, state *"Health Services should not be changed without the agreement of First Nations".*

This position was consistently endorsed by the participants at the Consultation Sessions. First Nations strongly stated that health services should not be changed without their agreement. They wish to be consulted on program issues that impact on their health and well-being. They also insist on having an active role in the decision-making process. They stated that there must be no more unilateral decisions made by MSB.

The need for a national joint decision-making process was unanimously accepted by the members of the JTF. A discussion took place on how this recommendation should be implemented. There was a concern that representatives could be arbitrarily appointed to a decision-making body without the democratic support of the First Nations or Inuit communities. It was agreed that representatives of the Assembly of First Nations, the Inuit Tapirisat and by the Innu and Non-Affiliated First Nations must be selected and appointed to be part of the decision-making process.

It was further agreed that these appointments must be endorsed at General Assemblies or like gatherings.

JTF Recommendation #7:

The Joint Task Force recommends:

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[3] The term "First Nation Organization" shall be taken to also include any comparable Inuit and Innu Organization.

MSB made a commitment to the JTF to review the NIHB Directives which define Prescribing Authorities and to consider the special circumstances encountered in the remote and isolated areas.

Section Seven

Definitions

The Joint AFN/MSB Task Force
on the
Future Management
of the
Non-Insured Health Benefits Program

Section Seven
Definitions and Acronyms

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1. Definitions Used in the JTF Report

First Nation Individuals:	Recognized Inuit, Innu and Registered Indians.
First Nation Leadership:	Chief's General Assembly of like gathering.
First Nation Organization:	This includes any comparable Inuit and Innu Organization.
Liberty Health:	Formerly Ontario Blue Cross.
Registered Indians:	All Indians, Inuit and Innu who are either registered or eligible for registration with DIAND.

2. Acronyms and Abbreviations Used in the JTF Report

A/DG	Acting Director General
A/RD	Acting Regional Director
AFN	Assembly of First Nations
AIAI	Association of Iroquois and Allied Indians
AMC	Assembly of Manitoba Chiefs
ANSC	Assembly of Nova Scotia Chiefs
BCR	Band Council Resolution
CWIS	Community Workload Increase System
CYI	Council of Yukon Indians
DFS	Departmental Financial System
DG	Director General
DIAND	Department of Indian Affairs and Northern Development
DM	Deputy Minister of Health Canada
FN	First Nations
FSIN	Federation of Saskatchewan Indian Nations

GC	Grand Council
GNWT	Government of the Northwest Territories
HWC	Health Canada (formerly Health and Welfare Canada)
INAC	Indian and Northern Affairs Canada
INHC	Innu Nation Health Commission
JTF	Joint Task Force
LIHC	Labrador Inuit Health Commission
MSB	Medical Services Branch of Health Canada
NIHB	Non-Insured Health Benefits (Program)
NIHBs	Non-Insured Health Benefits
NWT	Northwest Territories
OTC	Over-The-Counter Products
RD	Regional Director
RFP	Request for Proposal
SVS	Status Verification System
TC	Tribal Council
TWG	Technical Working Group
UNBI	Union of New Brunswick Indians

Appendix "A"

The Compiled Joint Task Force Recommendations

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Appendix "A"
The Compiled Joint Task Force Recommendations

1. Management Options

Recommendation #1:

The Joint Task Force recommends that no additional authorities related to the Non-Insured Health Benefits Program should be sought by Medical Services Branch until the NIHB Pilot Projects have been completed and evaluated.

2. Core Principles

Recommendation #2:

The Joint Task Force recommends that Core Principles be defined at the national level and that they be implemented by all Medical Services Branch Regions and First Nations and Inuit communities and organizations which manage the NIHB Program.

Recommendation #3:

The Joint Task Force recommends that the Principle of Health as a Treaty and/or Aboriginal and/or First Nations Right be resolved at the most senior political level pursuant to the December 1, 1994 Joint Task Force Resolution.

Recommendation #4:

The Joint Task Force recommends that Non-Insured Health Benefits continue to be provided to the On and Off-Reserve First Nations individuals of Canada. [1]

Recommendation #5:

The Joint Task Force recommends that Non-Insured Health Benefits continue to be provided without regard to the financial status of the First Nations individuals of Canada.

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[1] Throughout these JTF Recommendations and elsewhere in this Report, the term "First Nations individuals" shall be taken to mean "recognized Inuit, Innu and Registered Indians".

Recommendation #6:

The Joint Task Force recommends that:

a. Non-Insured Health Benefits must be provided when and as needed;

b. Medical Services Branch must ensure that no barriers impede accessibility to Non-Insured Health Benefits;

c. Medical Services Branch should immediately develop and implement a process to coordinate benefits which will allow the benefit or service to be provided without inconveniencing or adversely affecting the beneficiary.

d. Eligible First Nations individuals must declare any other benefit coverage to facilitate the delivery of benefits or services by either Medical Services Branch or the First Nation Organization[2] responsible for the management of the NIHB Program.

Recommendation #7:

The Joint Task Force recommends:

a. The establishment of Joint Decision-Making Bodies at both the National and Regional levels and that the mandate must be developed by the Minister and the National Aboriginal leaders;

b. The Aboriginal Representatives at the National level must be selected and appointed by the National Aboriginal leaders and that Non-Affiliated communities must be part of the decision-making process and that these appointments must be endorsed at General Assemblies or like gatherings.

c. The Aboriginal Representatives at the Regional levels must be selected by the appropriate political authorities.

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[2] The term "First Nation Organization" shall be taken to also include any comparable Inuit and Innu Organization.

3. Core Benefits

Recommendation #8:

The Joint Task Force recommends that Core Program Benefits, as defined by the National Joint Decision-Making Body, be established which are universally available, accessible and portable across Canada.

Recommendation #9:

The Joint Task Force recommends that there shall be standard national levels for Non-Insured Health Benefits which are defined by the National Joint Decision-Making Body and which are universally available to all First Nations individuals. The Joint Task Force recognized that in some Regions some of the Non-Insured Health Benefits may be provided either fully or in part by the provincial government.

Recommendation #10:

The Joint Task Force recommends that Medical Services Branch enforce the consistent interpretation and application of the Non-Insured Health Benefit Directives.

Recommendation #11:

The Joint Task Force recommends that the Joint Decision-Making Bodies review and revise the policy on Traditional Healers taking into account the recommendations of First Nations.

Recommendation #12:

The Joint Task Force recommends that the National Joint Decision-Making Body review and revise the Non-Insured Health Benefit Directive on Mental Health Services taking into account the recommendations of the First Nations.

Recommendation #13:

The Joint Task Force recommends that the Regional Joint Decision-Making Bodies:

a. regularly review the adequacy of the accommodations provided when eligible First Nations individuals are required to be away from home to access medical services.

b. review the adequacy of the funding allocated for meals when eligible First Nations individuals are away from home to access medical services.

4. Eligibility Criteria

Recommendation #14:

The Joint Task Force recommends that all Indians, Inuit and Innu who are either registered or eligible for registration with DIAND and are resident in Canada continue to receive Non-Insured Health Benefits.

5. Appeals Process

Recommendation #15:

The Joint Task Force recommends that there should be a national standard for the Non-Insured Health Benefits Program Appeals Process which is established and implemented at the Regional level. Each level of this Appeals Process must be clearly documented and distributed and must contain the following core elements:

a. An Appeals body must be established which is composed of an equal number of representatives from both the communities and the Non-Insured Health Benefits Program Managers;

b. There must be appropriate professional expertise available to assess the case;

c. The Appeals Process must be timely;

d. The Appeal decision must be communicated in writing, must clearly state the reason why the Appeal was either approved or denied and, when applicable, must define the next steps in the Appeals Process.

6. Client Identification

Recommendation #16:

The Joint Task Force recommends that

a. Medical Services Branch reinforce with the Providers of Service the current administrative practice that it is not necessary to present the Certificate of Indian Status to access Non-Insured Health Benefits;

b. Medical Services Branch provide a method for the Service Providers to verify identification beyond normal office hours and on weekends;

c. The Joint Decision-Making Bodies, in conjunction with DIAND and, where appropriate, the provincial and territorial governments, create one identification card that could be used to access all services.

7. Contract Negotiations

JTF Recommendation #17:

The Joint Task Force recommends that:

a. The First Nations must be active participants in the negotiations with the Providers of Service for the Non-Insured Health Benefits Program.

b. Joint First Nations and Medical Services Branch Negotiating Teams must be established at the national and regional levels by April 1, 1996.

8. Claims Processing

Recommendation #18:

The Joint Task Force recommends that any future contracts for claims payment processing include a clause to facilitate the assumption of responsibility for all or part of the Non-Insured Health Benefits Program by First Nations at a time of their own choosing.

9. Communications Strategy

Recommendation #19:

The Joint Task Force recommends that Medical Services Branch establish, by April 1, 1996, Joint First Nations/MSB Communications Teams at the National and Regional levels with a mandate to develop and implement an ongoing communications strategy to keep both the First Nations and the Providers of Service informed about the Non-Insured Health Benefits Program.

10. Handicapped and Disabled Individuals

Recommendation #20:

The Joint Task Force recommends the removal of any barriers restricting access to Non-Insured Health Benefits for persons with disabilities.

Appendix "B"

The Terms of Reference

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Appendix "B"
The Joint Task Force Terms of Reference

1. Introduction and Background

In 1992, the National Chief of the Assembly of First Nations and the Deputy Minister, Health Canada, met to discuss the Non-Insured Health Benefits (NIHB) Program. These discussions focused on the concerns of First Nations regarding the implementation of National NIHB Directives, the Blue Cross contractual arrangement, Program management and administration and the transfer of NIHB to First Nations control. The government concerns about the rising cost of service provision were also discussed.

As a result of these meetings, the National Chief and the Deputy Minister agreed to develop a partnership approach to examine both the existing and future management and administration of the NIHB Program. This partnership approach was intended to address those issues which would facilitate the First Nations' desires for greater involvement in and control of the Program.

2. Goal of the Joint AFN/MSB Task Force

Through an equal partnership approach the Joint Assembly of First Nations / Medical Services Branch (AFN/MSB) Task Force will develop a series of options for the future management of the NIHB Program aimed at enhancing program effectiveness and efficiency and facilitating First Nations involvement and control.

3. Objectives of the Joint AFN/MSB Task Force

a. To facilitate First Nations input into the Task Force review by:

   i. Soliciting First Nations input into the subjects under the Joint Task Force review;

   ii. Reviewing First Nations and MSB policy and position papers on the NIHB Program; and

   iii. Holding a series of regional Joint Task Force dialogues involving First Nations and MSB Regions on the subjects under the Joint Task Force review.

b. To identify and analyze the current status of the NIHB Program by:

i. Describing the current NIHB Program, including:

- what is in the Program;
- what is not in the Program;
- the exiting policies, procedures and authorities;
- Regional variations in Benefits and Services;
- current management procedures (e.g., the Blue Cross contract).

ii. Identifying current NIHB Program management issues by reviewing:

- the Auditor General's (AG) Report;
- the Joint AG and MSB Internal Audit (PARD) report; and
- any other evaluation documents which impact on the delivery of Non-Insured Health Benefits or Services.

iii. Reviewing existing National and Regional NIHB management systems, including:

- Blue Cross claims payment process;
- Status Verification System;
- other Regional Provider Systems.

iv. Identifying existing NIHB service delivery models, including:

- First Nations contractual agreements;
- the Government of the Northwest Territories contract;
- the James Bay Cree Service Delivery Arrangement.

c. To assess the current NIHB Program service delivery structure and systems to identify issues impacting on the present delivery of services.

d. To develop and recommend Core Principles for the NIHB Program.

e. To identify and recommend future management options for the delivery of a NIHB Program, which will include:

i. The feasibility and acceptability of proposed options;
ii. Central Agency authorities and other requirements to implement the options identified.

f. To develop and recommend an implementation strategy for joint presentation to the AFN National Chief and the Deputy Minister, Health Canada.

4. Accountability

The Joint AFN/MSB Task Force on the Future Management of Non-Insured Health Benefits is mandated under the authority of:

a. Resolution Number 22/92, passed at the XIIth Annual Chief's Assembly, June 23, 1992, at Fredericton, N.B.;

b. Correspondence between the Deputy Minister, Health Canada and the National Chief, the Assembly of First Nations, dated January 19, 1993.

The Joint AFN/MSB Task Force is jointly accountable to the Deputy Minister, Health Canada and the National Chief, Assembly of First Nations. To facilitate accountability, the Joint AFN/MSB Task Force will submit to the Deputy Minister and the National Chief:

a. Quarterly Progress Reports;
b. An Interim Report (July 1994);
c. NIHB Description Report (June 1994);
d. NIHB Management Issues Report (September 1994);
e. NIHB Draft Management Options Report (December 1994); and
f. A Final Report and Recommendations (February 1995).

5. Joint AFN/MSB Task Force Membership

The Joint AFN/MSB Task Force comprises the following members who have full voting privileges:

a. First Nations:

i. Chief Sydney Garrioch, Co-Chair,
Cross Lake First Nation, Manitoba;
ii. Chief Terry Paul,
Membertou First Nation, Nova Scotia;
iii. Chief Jean-Charles Pietacho,
Bande indienne de Mingan, Province of Quebec;
iv. Chief Leona Nahwegahbow [1],
Whitefish River First Nation, Ontario

v. Chief Jim Badger [2],
Sucker Creek First Nation, Alberta.

b. Medical Services Branch, Health Canada:

i. Paul Cochrane [3], Co-Chair,
Director General, NIHB;
ii. Claude Paradis [4],
Regional Director, Quebec Region;
iii. Joanne Meyer [5],
Assistant Regional Director, Saskatchewan Region;
iv. Helene Quesnel [6],
Director of Policy & Planning, NIHB Directorate;
v. Ginette Thomas [7],
Sr. Policy Advisor, Program, Policy and Planning.

6. Technical Working Group

To assist the Joint AFN/MSB Task Force in the fulfilment of its mandate, a Joint AFN/MSB Technical Working Group will be established to undertake a technical review and analysis of issues under the Task Force mandate. The Joint AFN/MSB Technical Working Group will report to the Joint Task Force and act under the functional direction of the Co-Chairpersons. The Technical Working Group will attend and participate in Joint Task Force deliberations as non-voting members.

The Joint AFN/MSB Technical Working Group will consist of four First Nations technicians and three MSB representatives.

7. Frequency of Meetings

The Joint AFN/MSB Task Force will meet on a monthly basis, at times and locations determined by the membership. Meetings may decrease to one two-day meeting every two or three months to enable the Technical Working Group to conduct the necessary work, review and analysis assigned by the Task Force Co-Chairs.

The Joint AFN/MSB Technical Working Group will meet as directed by the Co-Chairs of the Joint AFN/MSB Task Force.

8. Secretariat Services

Secretariat Services will be provided by the NIHB Directorate, Ottawa. A person will be identified to work with the Joint AFN/MSB Task Force.

Both the Assembly of First Nations and the NIHB Directorate, MSB, HQ, will alternate in taking minutes of meetings. Translation of minutes of the meetings and reports will be the responsibility of MSB.

The Assembly of First Nations and the NIHB Directorate will ensure the distribution of minutes, quarterly reports, preliminary reports, etc., to:

a. The Assembly of First Nations:

i. National Chief
ii. AFN Executive Committee
iii. AFN Confederacy of Nations
iv. Provincial/Territorial Indian Organizations
v. Tribal Councils
vi. First Nations Health Commissions
vii. Aligned First Nations.

b. Medical Services Branch:

i. Deputy Minister, Health Canada
ii. Regional Directors General
iii. Assistant Deputy Minister, MSB
iv. Directors General, MSB
v. Regional Directors, MSB
- Zone Directors
- Program Managers
- Nurses-in-Charge

v. Non-Aligned First Nations

1. Chief Leona Nahwegahbow resigned her membership on the Joint Task Force and Chief Nora Bothwell was appointed in her place.

2. Chief Jim Badger resigned his membership on the Joint Task Force and Chief Bernadette Unka was appointed in his place.

3. Paul Cochrane resigned as Co-Chair when he was appointed as Acting Assistant Deputy Minister and was replaced by Paul Glover, Acting Director General, NIHB.

4. Richard Legault, Acting Regional Director, Quebec Region, was appointed to the Joint Task Force in January 1996, following the retirement of Claude Paradis.

5. Joanne Meyer resigned her membership on the Joint Task Force upon her transfer to Ottawa and was replaced by Al Garman, Regional Director, Atlantic Region. Joanne Meyer continued to support the Joint Task Force as Director of the Joint Task Force Secretariat and a member of the Technical Working Group.

6. Helene Quesnel resigned her membership on the Joint Task Force upon her internal transfer to another Department and was replaced by Richard Jock, Regional Director, Ontario Region. Following his resignation from Health Canada, Richard Jock was replaced in January, 1996 by Abu Nazir, Acting Regional Director, Ontario Region.

7. Ginette Thomas resigned her membership on the Joint Task Force and was replaced by Jerome Berthelette, Director General, Policy and Planning.

Appendix "C"

The Consultation Workbook

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Appendix "C"
The Consultation Workbook

The Consultation Workbook, which is reproduced in the following pages, has been modified slightly by reducing the space available for written responses. The background information, questions and the basic format have not been changed.

NON-INSURED HEALTH BENEFITS

CONSULTATION WORKBOOK

First Nation or Inuit Community:	
Name of Representatives:	**1.** **2.**
Address:	
Telephone Number:	

1. The Consultation Process

During the Information/Orientation Sessions, your community representatives were provided with an overview of the benefits and services provided through the Non-Insured Health Benefits (NIHB) Program. The regional costs of the benefits and a description of the current program principles were provided, together with information on the external pressures that affect the NIHB Program.

The participants at the Information/Orientation Sessions were also given specific questions concerning the future management of the NIHB Program. They were encouraged to share the information with their home communities and to discuss the possible future management options for the Program.

Throughout the Information/Orientation Session, the participants were reminded that the two-day Consultation Session would be scheduled after a few weeks and that this would provide the opportunity for the community representatives to make their recommendations to the Joint Task Force.

2. The Consultation Workbook

We are providing you with this Consultation Workbook as an aid in preparing the recommendations from your community on the future management of the NIHB Program. The Workbook is laid out in the format of the questions that were raised at the Information/Orientation Session.

To help you prepare your response, at the Consultation Session we will provide you with the following additional documentation:

a. Discussion Paper on Management Options
b. Consultation Presentation package
c. Your community's 1993/94 NIHB benefit expenditures
d. Pilot Project Handbook

Question One: Future Management Options

The Discussion Paper on the Possible Management Options for the Non-Insured Health Benefits Program describes the Pros and Cons of the following possible management options:

1. **Status Quo:**
   Management remains the same as it is currently, with some administrative improvements.

2. **Co-Management:**
   The NIHB Program is jointly managed by Medical Services Branch (MSB) and First Nations.

3. **Administration through Contribution Agreement:**
   First Nations or Inuit communities administer the NIHB Program through a Contribution Agreement (similar to Medical Transportation).

4. **Private Health Insurance Plans:**
   Private insurance may be purchased by individuals or First Nations or Inuit communities to provide health benefits (i.e., First Nations Insurance).

5. **Integrated Community-based Health Service Model:**
   NIHB can be incorporated into an integrated Community Based-Health Services Agreement. These kinds of agreements can currently be chosen to provide community health services.

6. **Unconditional Transfer:**
   Transfer of NIHB to communities, Tribal, Provincial or National Organizations with no management conditions.

7. **Conditional Transfer:**
   Transfer of NIHB to communities, Tribal, Provincial or National Organizations with some management conditions.

8. **Self-Government:**
   Complete authority to manage all programs at the discretion of the First Nations or Inuit community leadership.

9. **Single Funding Mechanisms:**
All funding for community programs for all government departments is consolidated into one contribution agreement between Indian Affairs and the First Nation or Inuit community. The NIHB program is administered under MSB policies.

10. **Aboriginal for Profit Corporation:**
An Aboriginal for profit organization contracts with MSB and First Nations and Inuit communities to process claims for payment (i.e., Blue Cross Contract).

Please list your recommendations and suggestions for Future Management Options

QUESTION ONE:

What management options do you recommend for First Nations or Inuit communities?	
What management option would you consider for your community?	

Question Two: Core Principles

The NIHB Program currently operates under a set of Core Principles. Under these existing Principles, individuals can access NIHB anywhere in Canada and the Provider of Service automatically bills MSB. The AFN tabled Draft Principles for discussion purposes. The two sets of Principles are:

	MSB		AFN
1.	Payer of Last Resort.	1.	Health is a Treaty and First Nation Aboriginal Right.
2.	Benefits are based on Professional Medical or Dental judgment.	2.	Health Services are provided through the fulfilment of federal fiduciary responsibilities.
3.	All Registered Indians and Inuit are eligible for NIHB Benefits, whether they live On or Off-Reserve and regardless of their income level.	3.	The Crown is the primary provider of all Health Services, including NIHB.
4.	There is National Consistency in the NIHB Benefit Categories and in the Directives under which the Program operates.	4.	Health Services should be provided when and as needed without regard to financial status, and should be comprehensive, accessible and fully portable regardless of residence On or Off-Reserve or of country.
		5.	Health Services should not be changed without the agreement of First Nations.

Question Two:

Do you recommend that there should be Core Principles for the NIHB Program that are applied nationally to all First Nations and Inuit communities?	
If YES, what Core Principles do you recommend?	
If you recommend that there be NO nationally applied Core Principles, what program principles do you wish to see applied for your community?	

Question Three: Appeals Process

MSB has an Appeals Process for First Nations through which they can request approval for items which have been refused because they are not on the current benefit list. This appeal process differs from region to region.

Would you implement an Appeals Pprocess in the management option you choose for your community?	
What type of Appeals Process would you recommend when benefits are denied?	
How would your Appeals Process work?	
Do you recommend the present practice of regional Appeals Processes continue?	
Do you think there should be a national Appeals Process?	

Question Four: Client Identification

The current NIHB Program as operated by MSB does not require clients to carry special identification cards in order to obtain benefits. It is helpful if Registered Indian clients present their Certificate of Indian Status when accessing benefits or services but this is not necessary. The client must provide the following information when obtaining benefits or services:

1. Given and Surname (under which the client is registered with Indian Affairs)
2. Date of Birth (day, month, year)
3. Indian Registration Number

If you do not know your Indian Registration Number, you will be asked to provide:

4. Band Name
5. Treaty Number/Family Number

This information allows the Provider of Service to send the claim or bill for the goods or services provided to MSB for payment.

Question Four:

In the Management Option you recommended for your community, would you use the present method of client identification in order to receive benefits?	
Would you create your own Identification Card for the eligible people in your community?	
If you change the way your community members identify themselves for services, how would you let them know of the change in identification criteria?	

If you change the way your community members identify themselves for services, how would you inform the Suppliers of the change, so that they can identify your membership as eligible for benefits?	

Question Five: Contract Negotiation with Suppliers of Service

Medical Services Branch currently negotiates fee schedules and contracts with suppliers of services for the provision of goods and services. For example, fee schedules are negotiated for Dental Services as well as Pharmacy Services. These negotiations are regionally carried out with Provincial Professional Associations which are mandated to negotiate on behalf of their membership (dentists, optometrists, pharmacists). Because of the large volume of goods and services purchased by Medical Services, MSB can negotiate fees which are based on volume purchase. This enables MSB to obtain discounts on fees.

Does your community want to negotiate its own fee schedules for goods and services?	
Would your community prefer to continue using the existing fee schedules that were negotiated by Medical Services Branch?	
Would your community prefer to negotiate their own fee schedule directly with the Suppliers of Service?	

Question Six: Client Reimbursement

When your community members currently travel from province to province they can obtain NIHB benefits wherever they are. The Providers of Service understand how to identify your members as eligible for benefits under the NIHB Program and they may call MSB or Blue Cross to verify eligibility. They also bill MSB directly at the rates negotiated by MSB in the province in which the benefit is obtained. There is never any question as to what is a benefit, who is eligible and how to bill for service. This Canada-wide system provides full portability of benefits.

In the management option you recommended, if a community member requires a benefit (for example, Prescription drugs) when travelling outside your home province would the Supplier require the person to pay the cost directly and then to reclaim the payment from your administration upon presentation of the receipt?	
If your community intends to set up an administrative process where the community member can obtain benefits anywhere in Canada without paying first and then reclaiming the costs when coming back to the community, please describe how that would work.	

Question Seven:
How will you process claims for payment received from Providers of Service?

Medical Services Branch currently pays the claims for Pharmacy, Dental Services and Medical Supplies and Eequipment through Blue Cross every 15 days. All other claims for services are paid directly by MSB regional or zone offices. MSB pays all other claims for goods and services every 30 days. As is standard business practice, late payment charges are paid to the Suppliers if the payment is not made 30 days after receipt of a completed invoice.

Does your community wish to be responsible for paying all claims?	
Would you pay these claims through your own Band administration?	
Would you consider paying the claims through another agency. such as Blue Cross or a similar First Nations company?	
How often would you issue cheques to providers of service?	
Would you consider paying late charges if you do not pay your claims within 30 days?	

Question Eight:

Will your community provide services to both On and Off-Reserve Membership?

Medical Services Branch provides NIHB coverage for Registered Indian and Inuit individuals living both On and Off-Reserve.

Will your community provide services to both On and Off-Reserve membership?	
If you are providing services to both On and Off-Reserve, please describe how you will advise both groups.	
How will you advise your eligible membership of any changes in the way they obtain benefits?	

Question Nine: Benefit Issues

Medical Services Branch provides a national Non-Insured Health Benefits (NIHB) Program where the same benefits are available to all MSB clients regardless of residence in Canada. This means that a client may obtain a national level of benefit right across the country . The current benefits are:

1. Drugs prescribed by a physician or dentist and which are on the NIHB Formulary including Prescription Drugs and Over-The-Counter drugs.

2. Medical Supplies and Equipment

3. Vision Care (glasses and eye exams where they have been de-insured)

4. Dental Care

5. Transportation to Medical Services

6. Mental Health Services

7. Health Insurance Premiums (Alberta and B.C.)

8. Other Health Services, dependent on Regional circumstances

Do you recommend keeping the concept of Core Non-Insured Health Benefits (NIHB) which are universally available and portable to all First Nations and Inuit people across Canada?	
Do you wish to develop your own list of NIHB Benefits specifically for your community residents?	

If you want to develop your own NIHB Benefit list, what would you provide as benefits?	
What would you recommend as improvements to the existing MSB NIHB Benefit list?	

Thank you for taking the time to complete this Workbook. The Session facilitators will pass your recommendations and suggestions on to the Joint Task Force for inclusion in the Final Report.

Appendix "D"

Discussion Paper
on the
Possible Management Options

The Joint AFN/MSB Task Force
on the
Future Management
of the
Non-Insured Health Benefits Program

Discussion Paper
on the
Possible Management Options
for the
Non-Insured Health Benefits Program

Prepared for the
AFN/MSB Joint Task Force

INTRODUCTION

The Joint AFN/MSB Task Force on the Future Management of Non-Insured Health Benefits (NIHB) has the mandate to develop, through an equal partnership approach, a series of management options aimed at enhancing program effectiveness and efficiency and facilitating First Nations involvement and control.

This discussion paper was developed as a reference tool in order to assist First Nations in the development of their views toward future management options for the NIHB Program. The list of possible options attached is not intended to be all inclusive, but merely to act as a vehicle to create discussion.

The following table lists the current benefits and services available under the NIHB Program. The possible management options in this discussion paper fall within the three main categories for Pilot Projects as follows: Administrative Pilot Projects; Transfer Pilot Projects; and Combination Administrative/Transfer Pilot Projects. This discussion paper may be useful when considering future management options at the scheduled Consultation Sessions. Advice received from First Nations will be used by the Joint Task Force to develop a final report on recommendations for future management options for the NIHB Program.

Benefit Category	Status
Medical Transportation	A National NIHB Directive is available for this Service. Many First Nations currently manage this service. MSB processes claims for payment where Medical Transportation is not managed by a First Nation or Inuit administration.
Vision Care	A National Directive is available for the Eyeglasses portion of this benefit. Vision Care comprises of Eye Examinations and Eyeglasses in those Regions where Eye Examinations have been de-insured. Claims are processed for payment by MSB Regions.
Medical Supplies & Equipment	A list of eligible medical supplies and equipment and the established frequency limitations is available in a National Directive. This is scheduled for automation by Blue Cross on March 1, 1995. This category is available for management by First Nations or Inuit administration.
Prescription Drugs	A National Directive and Formulary is available for this benefit category. This benefit is available only for an administrative management option. Payment of claims is carried out by Blue Cross under a contract which expires in July 1997.
Dental Services	A National Directive and Schedule of Dental Services is available for this benefit category. This benefit is available for an administrative management option. Payment of claims is carried out by Blue Cross under a contract which expires in July 1997.
Other Medical Services (subject to Regional variations, e.g., Podiatrist Services)	Regional administrative procedures exist for these services. Claims for payments are processed by MSB Regions.

Possible Management Options

The pros and cons for these possible management options are listed in the following tables, together with a brief description of the option. The currently identified possible management options are:

1. Status Quo

2. Co-Management
   a. Interim
   b. Ongoing

3. First Nation/Inuit Administration through Contribution Agreement
   a. Continuing existing claims-processing mechanisms
   b. First Nation/Inuit processing claims

4. Private Health Insurance Plans
   a. Community
   b. Individual

5. Integrated Community-based Health Service Model

6. Transfer to a First Nation/Inuit Community
   a. Unconditional Transfer
   b. Conditional Transfer

Possible Management Options (Continued)

7. Transfer to a First Nation Tribal Council or Inuit Organization
   a. Unconditional Transfer
   b. Conditional Transfer

8. Transfer to a First Nation or Inuit Provincial or Territorial Organization
   a. Unconditional Transfer
   b. Conditional Transfer

9. Transfer to a National Organization
   a. Unconditional Transfer
   b. Conditional Transfer

10. Self-Government Model

11. Single Funding Mechanisms

12. Aboriginal "For Profit" Corporation

1. Status Quo:

In this Option, MSB continues to deliver the NIHB Program as it does at present.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1.Functional system. 2.Unique features: - no payment by client - full portability - no ID card. 3.National consistency. 4.Preserves the federal Fiduciary Responsibility.	1.Limited FN control. 2.Limited FN employment. 3.Inconsistency between Regions. 4.MSB's unilateral decision re the Blue Cross contract is not acceptable to FN and the Inuit. 5.Manitoba Regions FN have rejected the National Directives.	1.No change to existing processes.	1.Does not support enhanced FN/Inuit control.

2a. Interim Co-Management between First Nations/Inuit and MSB

MSB in partnership with the First Nations and the Inuit manages and administers the NIHB Program. This partnership approach could be at the National or Regional level. In this option, the Program is managed using existing policies. The development and implementation of new procedures and negotiations with suppliers of service would be conducted jointly. This option would be in place for a limited time period, such as one or two years, and could provide an opportunity for "on-the-job" training.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. Potential for co-training of FN & Inuit employees. 2. Provides a basis for the evaluation of the future management options. 3. Prepares for a smooth transition. 4. Allows for a partnership approach. 5. Preserves the Federal Fiduciary Responsibility. 6. Gain an understanding of current MSB management problems.	1. Growing pains, such as: - potential conflicts in co-management - potential conflict between MSB and FN/Inuit personnel. 2. Limited FN/Inuit control. 3. Potentially difficult to implement.	1. Allows FN/Inuit to gain the knowledge required to consider other future management options. 2. Effective means of gaining first-hand knowledge of the Program, leading to enhanced FN and Inuit control.	1. Pressure to provide increased administrative funding. 2. Potentially difficult to implement.

2b. Ongoing Co-management between First Nations/Inuit and MSB

MSB in partnership with the First Nations and the Inuit manages and administers the NIHB Program. This partnership approach could be at the National or Regional level. In this option, the Program is managed using existing policies. The development and implementation of new procedures and negotiations with suppliers of service would be conducted jointly. This differs from Option 2a in that this is an ongoing co-management, not a temporary transitional phase.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. Allows for a partnership approach. 2. Preserves the federal Fiduciary Responsibility. 3. Gain an understanding of current MSB management problems.	1. Growing pains, such as: - potential conflicts in co-management - potential conflicts between MSB and FN/Inuit personnel 2. Limited FN/Inuit control. 3. Potentially difficult to implement	1. Allows FN/Inuit to gain the knowledge required to consider other future management options. 2. Effective means of gaining first-hand knowledge of the Program leading to enhanced FN and Inuit control.	1. Pressure to provide increased administrative funding. 2. Potentially difficult to implement.

3a. First Nations/Inuit Administration under a Contribution Agreement

First Nations/Inuit administer the NIHB Program under current MSB policies and procedures. MSB and Blue Cross continue to pay the claims as in the current process.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. Partnership approach. 2. Gain an understanding of current MSB management problems. 3. Reduced turnaround time for decision making. 4. Faster Appeals Process. 5. Preserves the federal Fiduciary Responsibility. 6. Potential for FN/Inuit employment.	1. Limited FN/Inuit flexibility. 2. Potential conflict in the interpretation and the enforcement of NIHB Directives. 3. Growing pains, such as: - potential conflicts in co-management - potential conflicts between MSB and FN/Inuit personnel 4. FN/Inuit are not able to retain surpluses. 5. Agreements are only for a one-year period.	1. Allows FN/Inuit to gain the knowledge required to consider other future management options. 2. Effective means of gaining first-hand knowledge of the Program leading to enhanced FN and Inuit control.	1. Potential for Increased administrative costs due to dis-economies of scale. 2. Start-up costs necessary for the Community infrastructure.

3b. First Nations/Inuit Administration under a Contribution Agreement

First Nations/Inuit administer the NIHB Program under current MSB policies and procedures. First Nations/Inuit pay the claims for those benefits which they administer.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. Partnership approach. 2. Gain an understanding of current MSB management problems. 3. Reduced turnaround time for decision making. 4. Faster Appeals Process. 5. Preserves the federal Fiduciary Responsibility. 6. Potential for FN/Inuit employment.	1. Limited FN/Inuit flexibility. 2. Potential conflict in the interpretation and the enforcement of NIHB Directives. 3. Growing pains, such as: - potential conflicts in co-management - potential conflicts between MSB and FN/Inuit personnel 4. FN/Inuit are not able to retain surpluses. 5. Agreements are only for a one year period.	1. Allows FN/Inuit to gain the knowledge required to consider other future management options. 2. Effective means of gaining first-hand knowledge of the Program leading to enhanced FN and Inuit control.	1. Potential for increased administrative costs due to dis-economies of scale. 2. Start-up costs necessary for the community infrastructure.

4a. Health Benefit Insurance Plan for First Nation(s) or Inuit Community

First Nations/Inuit communities receive funding from MSB and negotiates the provision of benefits through a private insurer, such as Great West Life or Blue Cross. The funding is applied to payment of the insurance premiums.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. Improved FN/Inuit control by defining the levels and terms of the benefits and conditions of the insurance coverage. 2. Potential improvement in benefits. 3. Potential FN/Inuit employment in a self-administered plan. 4. Potential for profit.	1. Potential loss of national consistency. 2. Potential need for ID cards. 3. Potential that there may be no exceptions or appeals beyond the negotiated level of benefits. 4. Risk of premium escalation.	1. No additional administrative or infrastructure costs.	

4b. Health Benefit Insurance Plan for First Nation(s) or Inuit Individuals

First Nation or Inuit individuals receive funding directly and negotiate or purchase their own benefit provision through a private insurer.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. Individual could choose a plan tailored to his or her own personal needs without diminishing the current level of benefit coverage.	1. Potential loss of national consistency. 2. Potential need for ID cards. 3. There may be no exceptions or appeals beyond the negotiated level of benefits. 4. Risk of premium escalation. 5. High-risk individuals could be rejected. 6. Potential that an individual may not purchase coverage, expecting that MSB will still provide NJHB.	1. No additional administrative or infrastructure costs.	1. Potential for increased political pressure if individuals decline to insure privately but expect MSB to provide NIHB coverage.

5. Integrated Community-based Health Services Approach to Individual First Nations & Inuit

First Nations/Inuit assume the management of the NIHB Program together with any other first-level community health services that the community wishes to manage.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. Individual FN/Inuit communities have the responsibility for the management of the NIHB Program at the community level. 2. Individual FN/Inuit communities establish their own community health management system. 3. An overall funding agreement can be approved for a five-year period, with annual approval of the budget.	1. Communities could not keep any surplus. 2. New programs or benefit levels could not be established. 3. Communities may not become the direct employer of the employees.	1. Partnership approach allows the FN/Inuit community to gain the knowledge required to consider other potential management options. 2. Effective means of gaining first-hand knowledge of the Program leading to enhanced FN and Inuit control. 3. MSB employees remain federal public servants.	1. Requires start-up costs for the community infrastructure.

5. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
4. Communities can receive on-the-job training in the administration and delivery of NIHB. 5. One-time funding may be available to support developmental activities and the creation of a work plan. 6. Resources may be reallocated between MSB mandated services. 7. Provides a starting point to assume enhanced FN/Inuit control. 8. Maintains the federal Fiduciary responsibility. 9. Potential for FN/Inuit employment.			

6a. Unconditional Transfer to First Nations/Inuit Communities

A First Nation/Inuit community assumes full responsibility for providing the NIHB Program. This transfer includes:

a. the description of the Benefits list;
b. the identification of the eligible recipients;
c. the development of policies and procedures;
d. the development of an Appeals and Exceptions Process;
e. the granting prior approvals;
f. contract and price negotiations with providers of service;
g. the processing of claims for payments.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. FN/Inuit communities assume full control of the NIHB. 2. Transfer of employment from MSB to FN/Inuit communities. 3. Potential for faster turnaround time on Appeals and Exceptions decisions.	1. Potential capping of funds to FN/Inuit communities. 2. Potential conflicts between the FN/Inuit administration and their own Band members when administering the NIHB Program.	1. FN/Inuit communities take full responsibility for the management and control of the NIHB program.	1. Start-up costs needed for the necessary community infrastructure.

6a. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
4. FN/Inuit administration is directly accountable to the membership. 5. Communities may design the NIHB Program to meet their unique needs and to allocate funds according to community priorities without diminishing current Benefit levels. 6. Agreements can be for a five-year duration with a pre-defined formula for annual price and volume adjustments. 7. Communities retain unspent balances and use them for other health related purposes.	3. Potential dis-economies of scale through loss of volume negotiating power. 4. Potential requirement for ID cards to show the supplier the member is eligible for benefits. 5. Potential loss of national consistency. 6. Potential loss of current universality and portability. 7. Potential difficulties with the community membership and with Suppliers of Service during the transition period.		

6a. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
8. Pre-transfer funding may be available. 9. When NIHB is transferred with other community health programs, it provides resources for the ongoing health management structures at the community level. 10. Potential for profit.	8. Potential loss of Federal Fiduciary Responsibility. 9. FN/Inuit communities are responsible for any annual financial deficit.		

6b. Conditional Transfer to Individual First Nations/Inuit Communities

First Nations/Inuit communities assume full responsibility for providing NIHB within some pre-determined parameters. The First Nations/Inuit communities would assume responsibility for processing the payment of claims, and would be responsible for implementing:

a. MSB National Directives;
b. MSB Principles;
c. MSB eligibility criteria;
d. MSB procedures;
e. MSB pricing structure for goods and services.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. FN/Inuit communities assume full control of the NIHB Program within MSB parameters. 2. Transfer of employment to FN and Inuit communities. 3. Potential for faster turnaround time for Appeals and Exceptions.	1. Potential capping of funds to FN/Inuit communities. 2. Potential conflicts between the FN/Inuit administration and their own Band members when administering the NIHB Program.	1. FN/Inuit communities take full responsibility for the managment and control of the NIHB program.	1. Start-up costs needed for the necessary community infrastructure.

6b. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
4. The FN/Inuit administration is directly accountable to its membership. 5. Agreements can be for a Five-year duration with a pre-defined formula for annual price and volume adjustments. 6. Communities retain unspent balances and use them for other health -related purposes. 7. Pre-transfer funding may be available.	3. Potential dis-economies of scale through loss of volume negotiating power. 4. Potential requirement for ID cards to show the supplier that the member is eligibile for benefits. 5. Potential loss of national consistency. 6. Potential loss of current universality and portability. 7. Potential difficulties with the community membership and with Suppliers of Service during the transition period.		

6b. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
8. When NIHB is transferred with other community health programs, it provides resources for the on-going health management structures at the community level. 9. Potential for profit.	8. Potential loss of federal Fiduciary Responsibility. 9. FN/Inuit communities are responsible for any annual financial deficit.		

7a. Unconditional Transfer to FN Tribal Councils or Inuit Organizations

First Nation Tribal Councils or Inuit Organizations assume full responsibility for providing the NIHB Program, including:

a. the description of the Benefits list;
b. the identification of the eligible recipients;
c. the development of policies and procedures;
d. the development of an Appeals and Exceptions Process;
e. the granting of prior approvals;
f. contract and price negotiations with Providers of Service;
g. the processing of claims for payments.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. FN/Inuit communities assume full control of the NIHB Program. 2. Transfer of employment from MSB to FN/Inuit communities.	1. Potential capping of funds to FN/Inuit communities. 2. Potential conflicts between the FN/Inuit administration and the Band members when administering the NIHB Program.	1. FN/Inuit communities take full responsibility for the managment and control of the NIHB Program.	1. Start-up costs needed for the necessary community infrastructure.

7a. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
3. Potential for faster turnaround time on Appeals and Exceptions decisions. 4. FN/Inuit administration is directly accountable to the membership. 5. Communities may design the NIHB Program to meet their unique needs and to allocate funds according to community priorities without diminishing current Benefit levels. 6. Agreements can be for a Five-year duration with a pre-defined formula for annual price and volume adjustments.	3. Potential dis-economies of scale through loss of volume negotiating power. 4. Potential requirement for ID cards to show the supplier the member is eligible for benefits. 5. Potential loss of national consistency. 6. Potential loss of current universality and portability. 7. Potential difficulties with the community membership and with Suppliers of Service during the transition period.		

7a. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
7. Communities retain unspent balances and use them for other health -related purposes. 8. Pre-transfer funding may be available. 9. When NIHB is transferred with other community health Programs, it provides resources for the on-going health management structures at the community level. 10. Potential for profit.	8. Potential loss of federal Fiduciary Responsibility. 9. FN/Inuit communities are responsible for any annual financial deficit.		

7b. Conditional Transfer to FN Tribal Councils or Inuit Organizations

First Nation Tribal Councils or Inuit Organizations assume full responsibility for providing the NIHB Program within some pre-determined parameters. The First Nations Tribal Council or the Inuit Organization would assume the responsibility for processing the payment of claims, and would be responsible for implementing:

a. MSB National Directives;
b. MSB Principles;
c. MSB eligibility criteria;
d. MSB procedures;
e. MSB pricing structure for goods and services.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. The FN Tribal Council or Inuit organization assumes full control of the NIHB Program within MSB parameters. 2. Transfer of employment to FN and Inuit organizations. 3. Potential for faster turnaround time for processing Appeals and Exceptions.	1. Potential capping of funds for the NIHB Program. 2. Potential conflicts between the FN/Inuit administration and Band members when administering the NIHB Program. 3. Potential dis-economies of scale through loss of volume negotiating power.	1. FN/Inuit organizations take full responsibility for the management and control of the NIHB Program.	1. Start-up funding is necessary to develop the infrastructure.

7b. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
4. The FN or Inuit administration is directly accountable to the organizations members. 5. Agreements can be for a Five-year duration with a pre-defined formula for annual price and volume adjustments. 6. FN/Inuit organizations can retain unspent balances and use them for other health-related purposes. 7. Pre-transfer funding may be available.	4. Potential requirement for ID cards to show the supplier that the member is eligible for benefits. 5. Potential loss of national consistency. 6. Potential loss of current universality and portability. 7. Potential difficulties within the member communities and Suppliers of Service during the transition period. 8. Potential loss of federal Fiduciary Responsibility.		

7b. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
8. When NIHB is transferred with other community health programs, it provides resources for ongoing health management structures. 9. Potential for profit.	9. The FN/Inuit organization is responsible for any annual deficit. 10. Potential for conflict between member communities regarding the Program priorities.		

8a. Unconditional Transfer to a First Nation or Inuit Provincial/Territorial Organizations

A First Nation or Inuit Provincial or Territorial Organization assumes full responsibility for providing the NIHB Program. This responsibility includes:

a. the description of the Bbenefits list;
b. the identification of the eligible recipients;
c. the development and establishment of policies and procedures;
d. the development and implementation of an Appeals and Exceptions Process;
e. the granting of prior approvals;
f. contract and price negotiations with the Providers of Service;
g. the processing of claims for payments.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. The FN/Inuit PTO assumes full control of the NIHB program. 2. Transfer of employment from MSB to the FN/Inuit organizations. 3. Potential for faster turnaround time on Appeal and Exception decisions.	1. Potential capping of funds to communities. 2. Potential conflict between the FN/Inuit administration and the community members. 3. Potential dis-economies of scale through reduced bulk negotiating power.	1. The FN/Inuit Organization takes full responsibility for the management and control of the NIHB Program.	1. Start-up costs are required to develop the necessary infrastructure. 2. Potential need to continue services to unaligned communities.

8a. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
4. The FN/Inuit Organization is accountable to its membership. 5. The Organisation can design the NIHB Program to meet unique regional needs and to allocate funds in accordance with the priorities of member communities without diminishing current Benefit levels. 6. Agreements can be for a five-year duration with pre-defined methods for annual price and volume adjustments.	4. Potential requirement for ID cards to identify eligible recipients. 5. Potential loss of national consistency, universality and portability. 6. Potential difficulties with recipients and suppliers during the transition period. 7. Potential loss of federal Fiduciary Responsibility. 8. Potential for conflict between communities and the organizations when local priorities differ.		3. Potential political involvement if communities become dissatisfied with service received from the Provincial/Territorial Organizations.

8a. (Continued)

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
7. The organizations can retain unspent balances for health-related purposes. 8. Pre-Transfer funding may be available. 9. When the NIHB is transferred with other community health Programs it provides resources for ongoing health management structures at the organizations and community level. 10. Potential for profit.	9. Potential disruption of service if communities withdraw from their association with the organizations. 10. Potential difficulty in obtaining a clear mandate from each member community.		

8b. Conditional Transfer to a First Nation or Inuit Provincial/Territorial Organizations

A First Nation or Inuit Provincial or Territorial Organization assumes responsibility for providing the NIHB Program within some pre-determined parameters. The Provincial or Territorial Organizations would assume the responsibility for processing the payment of claims and would be also responsible for implementing:

a. MSB National Directives;
b. MSB Principles;
c. MSB eligibility criteria;
d. MSB procedures;
e. MSB pricing structure for goods and services.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. The FN/Inuit PTO assumes full control of the NIHB Program. 2. Transfer of employment from MSB to the FN/Inuit organizations. 3. Potential for faster turnaround time on Appeal and Exception decisions.	1. Potential capping of funds to communities. 2. Potential conflict between the FN/Inuit administration and the community members. 3. Potential dis-economies of scale through reduced bulk negotiating power.	1. The FN/Inuit organization takes full responsibility for the management and control of the NIHB Program.	1. Start-up costs are required to develop the necessary infrastructure. 2. Potential need to continue services to unaligned communities.

8b. Continued

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
4. The FN/Inuit organization is accountable to its membership. 5. Agreements can be for a five-year duration with pre-defined methods for annual price and volume adjustments. 6. The Organization can retain unspent balances for health-related purposes. 7. Pre-Transfer funding may be available.	4. Potential requirement for ID cards to identify eligible recipients. 5. Potential loss of national consistency, universality and portability. 6. Potential difficulties with recipients and suppliers during the transition period. 7. Potential loss of federal Fiduciary Responsibility. 8. Potential for conflict between communities and the organisations when local priorities differ.		3. Potential political involvement if communities become dissatisfied with service received from the Provincial/Territorial Organizations.

8b. Continued

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
8. When the NIHB Program is transferred with other community health programs it provides resources for on-going health management structures at the organization and community level. 9. Potential for profit.	9. Potential disruption of service if communities withdraw from their association with the organisations. 10. Potential difficulty in obtaining a clear mandate from each member community		

9a. Unconditional Transfer to a National Organization

A First Nation or Inuit National Organization (for example, the Assembly of First Nations) assumes full responsibility for providing the NIHB Program. This responsibility includes:

a. the description of the Benefit list;
b. the identification of the eligible recipients;
c. the development and establishment of policies and procedures;
d. the development and implementation of an Appeals and Exceptions Process;
e. the granting of prior approvals;
f. contract and price negotiations with the Providers of Service;
g. the processing of claims for payments.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
As described in Option 8a			

9b. Conditional Transfer to a National Organization

A First Nation or Inuit National Organization (for example, the Assembly of First Nations) assumes the responsibility for providing the NIHB Program within some pre-determined parameters. The National Organization would assume the responsibility for processing the payment of claims and would also be responsible for implementing:

a. MSB National Directives;
b. MSB Principles;
c. MSB eligibility criteria;
d. MSB procedures;
e. MSB pricing structure for goods and services.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
As described in Option 8b.			

10. Self-Government Model

Under the Self-Government Model, the First Nation or Inuit community has complete authority to allocate health resources to community-based priorities, as long as mandatory community health programs are provided.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. Individual FN/Inuit communities assume full control of NIHB and Community Health programs. 2. Transfer of employment from MSB to FN/Inuit communities. 3. There are no restrictions on how health resources are utilized. 4. Potential for faster decisions on Appeals and Exceptions. 5. The FN/Inuit administration is directly accountable to its membership.	1. Potential capping of funds to FN/Inuit communities. 2. Potential conflict between the FN/Inuit administration and its membership when administering the Program. 3. Potential requirement for ID cards to demonstrate eligibility to service providers. 4. Potential loss of federal Fiduciary Responsibility. 5. Potential difficulties with suppliers during transition phase.	1. FN and Inuit communities assume full responsibility for management and control of all Community Health programs including NIHB.	1. Start-up costs are required to develop the necessary infrastructure.

10. Continued

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
6. Capital Resources, including fixed assets, may be included in the agreement. 7. Resources associated with health services at the community, Zone and Regional level can be included in the self-government arrangement. 8. Resources are provided for planning as with the Transfer agreements. 9. Under the Self-Government model there are fewer reporting requirements. 10. Potential for profit.	6. MSB's residual role under Self-Government is not yet defined. 7. Potential loss of universality, portability and national consistency. 8. Potential dis-economies of scale during negotiations with suppliers of goods and services.		

11. Single Funding Mechanisms

A First Nation or Inuit community includes funding for the NIHB Program in the negotiations for a Single Funding Agreement. These Agreements, made between the individual community and DIAND, include resources from other Departments.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
The Pros and Cons are as defined in Option #6 with the additional points as shown below			
1. Assist FN and Inuit communities in consolidating resource management and accounting. 2. Increased flexibility allows a comprehensive approach to providing community programs.	No Additional Points	No Additional Points	No Additional Points

12. Aboriginal "For Profit" Corporation

An Aboriginal For Profit Corporation contracts with MSB and First Nations and Inuit communities to process claims for the NIHB Program in similar fashion to the Blue Cross contract.

FN/Inuit Pros	FN/Inuit Cons	MSB Pros	MSB Cons
1. Creates employment for FN & Inuit individuals. 2. Potential for profit. 3. Potential to become a claims processor for other corporations or professional organizations. 4. Potential to become an insurer.	1. Potential lack of skilled employees. 2. Reduced accountability to the community membership.	1. More acceptable to FN and Inuit communities than the Blue Cross contract.	None Noted

Appendix "E"

Trend Analysis of NIHB Expenditures

The Joint AFN/MSB Task Force
on the
Future Management
of the
Non-Insured Health Benefits Program

Appendix "E"
Trend Analysis of NIHB Expenditures

1. Overview

This Appendix is extracted from the Non-Insured Health Benefits "Year End Report, 1994-95" prepared by the NIHB Program Analysis Division.[1] The graphs and tables attached at the end of this Appendix are intended to demonstrate the trends in NIHB expenditures at both the National and Regional level.[2] The sources for the data used to prepare this Appendix are:

a. Statistics Canada;
b. the Status Verification System (SVS);
c. the Departmental Financial System (DFS);
d. the Community Workload Information System (CWIS).

2. National

a. Population Growth

The figures displayed in Figure E (1) at the end of this Section display the growth in the First Nations and Inuit population eligible to receive benefits under the NIHB Program. The population is the fastest growing population in Canada in comparison to the overall Canadian growth rate.

The First Nations population is drawn from the Status Verification System (SVS) operated from Medical Services Branch (MSB), based on data provided by the Department of Indian Affairs and Northern Development (DIAND) and supplemented by MSB Regional offices.

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[1] Copies of the NIHB Year End Report 1994-1995 may be obtained from the MSB Regional Offices.

[2] The conclusions drawn from the reported data are those made by the NIHB Program Analysis Division.

b. NIHB National Expenditure Trends

Figure E (2), attached at the end of this Appendix, demonstrates the growth in NIHB total expenditures over the past five years. The rate at which the expenditures are increasing has slowed from an annual increase of 20.9% in 1991/92 to an annual increase of 6.6% in 1994/95. This rate of change is demonstrated in Figure E (3).

The NIHB Year End Report 1994-1995 states that growth has been reduced largely as a result of the following factors:

i. The transfer of Programs from NIHB, largely in the Health Care and Hospital Services Benefits (e.g., Building Healthy Communities);

ii. The levelling of cost growth for pharmaceutical products;

iii. Reduced growth in utilization in certain Regions (e.g., Pharmacy in Atlantic and Alberta; Dental Care in Saskatchewan; both Pharmacy and Dental Care in Quebec).

Medical Transportation:

Expenditures for Medical Transportation are growing at a rate of 9.0%, which cannot be sustained within the capacity of the Envelope System of Budgetary Control. This is the case in every Region with the exception of Quebec and Saskatchewan.

Within the Medical Transportation component of NIHB, the growth ranged from a high of 16.7% in Ontario to a low of -0.9% in Quebec.

Dental Benefits:

Expenditures on Dental Benefits have increased at a faster rate than other Benefits in the period from 1987/88 to 1994/95. Dental costs rose by over 200% from $38.4 million to $116.3 million. Pharmacy costs grew by 178.4% while Transportation expenditures rose by 130.4%. Vision Care cost increases have been more modest, rising only 52.7% in this seven-year period.

Health Care Benefits:

Health Care Benefit expenditures declined in 1994/95 due to the transfer of Mental Health, Home Nursing and Solvent Abuse funding from NIHB to the Building Healthy Communities Initiative. The Health Care and Hospital Services category (excluding Health Care Premiums in Alberta and B.C.) declined by 12.5%.

Conclusion[3]:

Overall, it is evident that the trend to lower growth will not, in itself, be sufficient to enable the program to provide the existing level of benefits within the limitations of the Indian and Inuit Health Programs Envelope.

3. NIHB Regional Expenditure Trends

Figure E (4) details the actual 1994/95 NIHB expenditures by both Benefit type and by Region. These figures clearly demonstrate the overall increase in expenditures rising from under $200 million in 1987/88 to almost $500 million in 1994/95.

Figure E (5) shows the percentage of the 1994/95 NIHB expenditures in each Region for each Benefit type.

Figure E (6) details the actual expenditures for each NIHB Benefit type in each Region for the eight-year period 1987/88 to 1994/95.

Tables E (5) - E (15) show the actual five-year expenditures for each Region and for each Benefit type for the financial years 1990/91 to 1994/95.

Conclusions[4]:

The growth in NIHB costs are the result of the following factors:

a. the cost of benefits (e.g., the rising costs of prescription drugs, transportation costs);

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3 NIHB Program Analysis Division

4 NIHB Program Analysis Division

b. growth in the eligible population;

c. the proportion of eligible clients using the Program (i.e., claims per eligible client);

d. the number of times each claimant uses a benefit (i.e., Utilization per Claimant);

e. provincial health care reforms and de-insurance.

The total NIHB expenditures in the Manitoba Region have increased at a faster rate (76.8%) than any other Region in the period from 1990/91 to 1994/95. The Atlantic Region at 71.0% and the Quebec Region at 60.2% had the next largest growth rates. By comparison, the Region with the lowest growth rate in expenditures was the Yukon Region at 1.5%.

Expenditures in Medical Transportation grew most in the Atlantic Region (98.4%) and least in the Yukon Region (33.2%) in this period.

Pharmacy expenditures in the Northwest Territories rose by 131.4% in the five-year period ending in 1994/95, representing the largest proportional increase. Manitoba Region (95.0%) and the Pacific Region (87.1%) followed.

Growth in the Dental Benefit category was the highest in the Alberta Region at 85.9% and next highest in the Quebec Region (75.1%).

Figure E (1): Eligible Clients by Region, 1992/93 to 1994/95

Regions	Indians			Inuit			Total Indian/Inuit Population		
	1992/93	1993/94	1994/95	1992/93	1993/94	1994/95	1992/93	1993/94	1994/95
Atlantic	22,308	23,186	24,277	5,503	5,577	5,633	27,811	28,763	29,910
Quebec	42,832	44,074	45,572	83	184	301	42,915	44,258	45,873
Ontario	122,820	126,496	131,721	232	275	300	123,052	126,771	132,021
Manitoba	81,916	85,195	89,304	8	10	14	81,924	85,205	89,318
Saskatchewan	82,279	85,888	90,344	9	10	12	82,288	85,898	90,356
Alberta	69,341	70,570	72,346	257	162	183	69,598	70,732	72,529
Pacific	97,170	98,132	98,482	87	102	116	97,257	98,234	98,598
Yukon	6,357	6,509	6,672	50	54	53	6,407	6,563	6,725
NWT	12,469	13,014	13,401	24,967	24,888	25,698	37,436	37,902	39,099
TOTAL	**537,492**	**553,064**	**572,119**	**31,196**	**31,262**	**32,310**	**568,688**	**584,326**	**604,429**

Figure E (2)
NIHB Annual Expenditures, 1990/91 to 1994/95

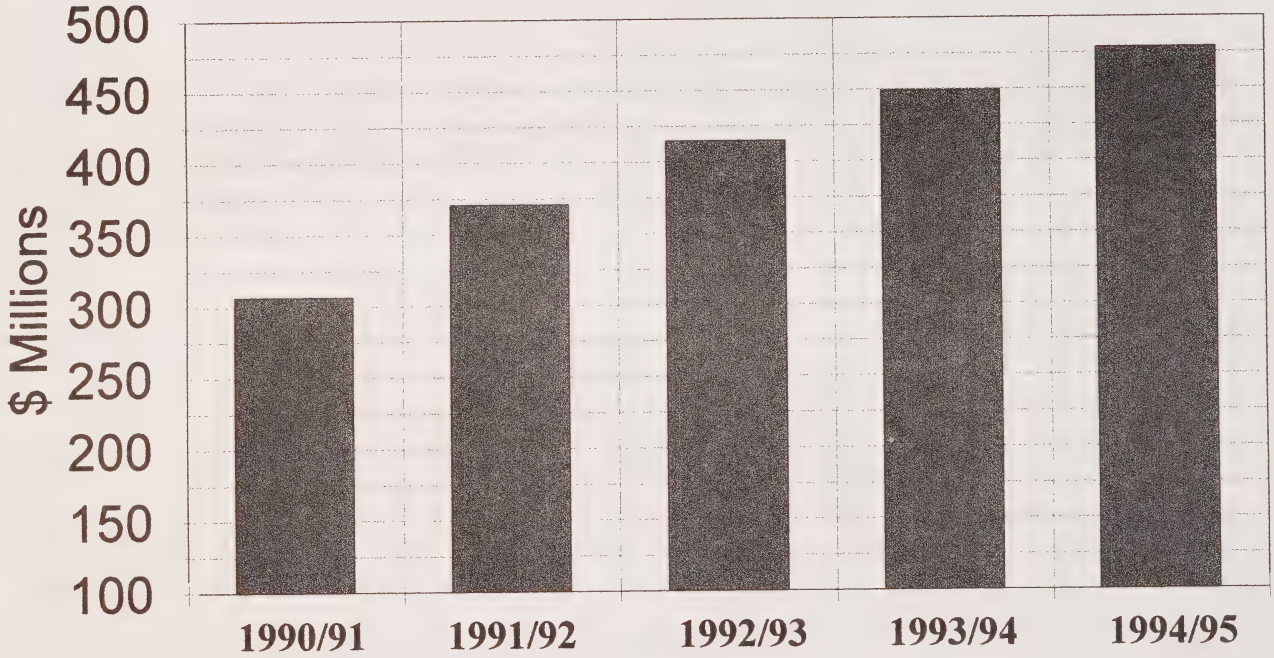
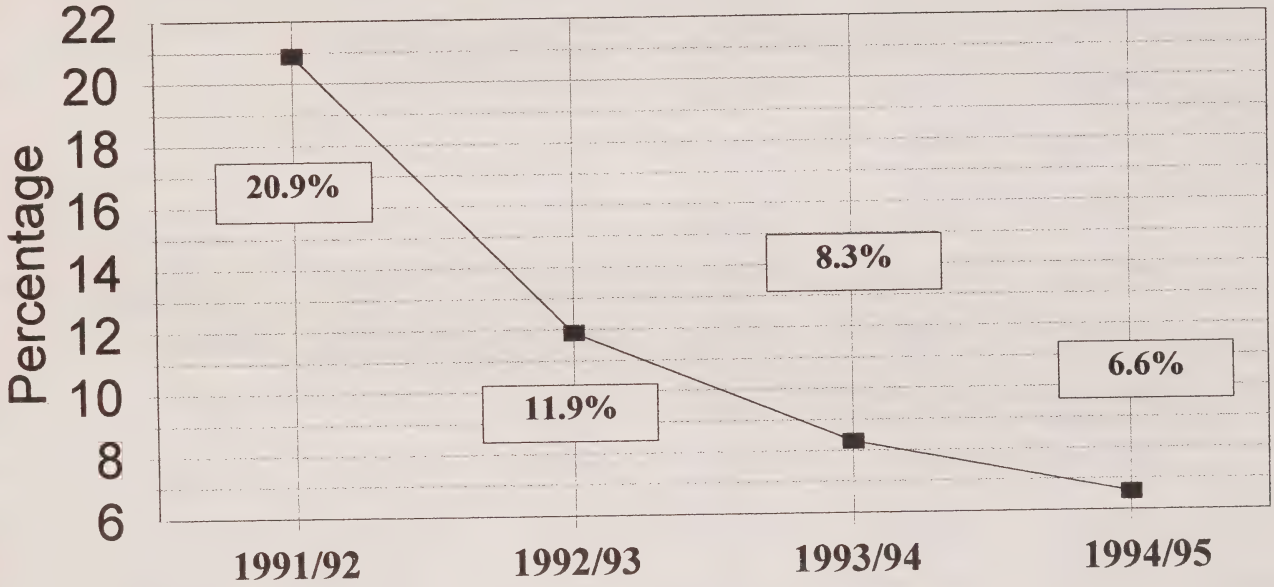


Figure E (3)
Rate of Growth in NIHB Annual Expenditures



The Joint AFN/MSB Task Force Report and Recommendations
Volume 1, Appendix "E", Page 149

Figure E (4)
NIHB Expenditures by Benefit and Region - 1994/95

Region	Pharmacy	Transportation	Dental Care	Health Care	Vision Care	Total	% Change from 93/94
Atlantic	8,253,200	5,862,200	4,113,000	317,600	1,359,700	19,905,700	2.1 %
Quebec	10,482,700	16,694,300	9,927,800	982,100	775,500	38,862,400	1.4 %
Ontario	27,525,000	23,533,400	25,329,600	7,669,800	4,046,800	88,104,600	10.6 %
Manitoba	20,141,500	32,431,900	13,054,200	5,430,500	1,304,500	72,362,600	9.7 %
Saskatchewan	22,919,100	19,078,700	12,196,300	4,382,000	1,859,300	60,435,400	5.3 %
Alberta	24,562,900	20,782,600	17,696,900	28,399,400	2,966,200	94,408,000	5.5 %
Pacific	21,773,700	10,654,600	19,634,800	12,674,700	2,473,600	67,211,400	6.3 %
Yukon	1,517,500	1,275,400	1,459,300	177,000	166,400	4,595,600	7.1 %
NWT	4,084,900	9,086,400	7,993,000	584,800	1,088,400	22,837,500	7.9 %
Total	141,260,500	139,399,500	111,404,900	60,617,900	16,040,400	468,723,200	6.6 %

Note 1: The Total 1994/95 NIHB Expenditures excludes the $9.9 Headquarters costs, primarily for the Blue Cross contract.
Note 2: The Category "Health Care" includes Hospital Services, Health Care and Premiums.

Figure E (5)
Regional NIHB Percentage Benefit Expenditures - 1994/95

Region	Pharmacy	Transportation	Dental Care	Health Care	Vision Care	Total
Atlantic	5.80	4.20	3.70	0.50	8.50	4.30
Quebec	7.40	12.00	8.90	1.60	4.80	8.30
Ontario	19.50	16.90	22.70	12.70	25.20	18.90
Manitoba	14.30	23.30	11.70	9.00	8.10	15.40
Saskatchewan	16.20	13.70	10.90	7.20	11.60	12.90
Alberta	17.40	14.90	15.90	46.80	18.70	20.10
Pacific	15.40	7.60	17.60	20.90	15.40	14.30
Yukon	1.10	1.00	1.30	0.30	1.00	1.00
NWT	2.90	6.50	7.20	1.00	6.80	4.90
Total	100.00	100.00	100.00	100.00	100.00	100.00

Note : The Category "Health Care" includes Hospital Services, Health Care and Premiums.

Figure E (6)
NIHB Annual Expenditures by Benefit - 1987/88 to 1994/95

NIHB Category	1987/88	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	60,515,000	61,881,000	71,016,000	84,937,000	104,531,000	113,844,000	128,007,000	139,400,000
Prescription Drugs	52,489,000	61,421,000	74,731,000	84,851,000	104,415,000	120,856,000	133,481,000	146,131,000
Dental Care	38,412,000	46,101,000	54,532,000	74,146,000	84,427,000	97,976,000	110,346,000	116,273,000
Health Care	18,586,000	19,289,000	19,778,000	29,070,000	36,675,000	41,196,000	36,735,000	32,150,000
Premiums	11,165,000	13,566,000	16,211,000	19,186,000	22,797,000	24,387,000	26,350,000	28,610,000
Vision Care	10,505,000	11,674,000	13,110,000	14,416,000	17,744,000	16,386,000	14,101,000	16,040,000
TOTALS	191,672,000	213,932,000	249,378,000	306,606,000	370,589,000	414,645,000	449,020,000	478,604,000
% Increase Over Previous Year	15.80	11.61	16.57	22.95	20.87	11.89	8.29	6.59

Figure E (7)
Atlantic Region NIHB Annual Expenditures by Benefit
1990/91 to 1994/95

Benefit	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	2,955,000	3,797,000	4,776,000	5,256,000	5,862,000
Prescription Drugs	4,754,000	6,253,000	7,116,000	7,474,000	8,253,000
Dental Care	2,636,000	3,038,000	3,508,000	3,626,000	4,113,000
Health Care	683,000	518,000	843,000	2,149,000	318,000
Vision Care	614,000	1,052,000	971,000	993,000	1,360,000
TOTAL	11,642,000	14,658,000	17,214,000	19,498,000	19,906,000
% Increase	16.20	25.91	17.44	13.27	2.09

Figure E (8)
Quebec Region NIHB Annual Expenditures by Benefit
1990/91 to 1994/95

Benefit	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	9,694,000	13,737,000	14,823,000	16,535,000	16,694,000
Prescription Drugs	6,975,000	9,501,000	9,447,000	10,086,000	10,483,000
Dental Care	5,669,000	6,354,000	8,300,000	9,446,000	9,928,000
Health Care	1,092,000	2,026,000	1,619,000	1,356,000	982,000
Vision Care	823,000	1,090,000	675,000	710,000	776,000
TOTAL	24,253,000	32,708,000	34,864,000	38,133,000	38,863,000
% Increase	18.60	34.86	6.59	9.38	1.91

Figure E (9)
Ontario Region NIHB Annual Expenditures by Benefit
1990/91 to 1994/95

Benefit	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	13,223,000	15,863,000	17,987,000	20,853,000	23,533,000
Prescription Drugs	17,304,000	16,872,000	21,009,000	24,397,000	27,525,000
Dental Care	15,109,000	18,105,000	20,713,000	23,379,000	25,330,000
Health Care	5,737,000	5,465,000	7,344,000	7,806,000	7,670,000
Vision Care	4,316,000	4,132,000	3,162,000	3,237,000	4,047,000
TOTAL	55,689,000	60,437,000	70,215,000	79,672,000	88,105,000
% Increase	31.00	8.53	16.18	13.47	10.58

The Joint AFN/MSB Task Force Report and Recommendations
Volume 1, Appendix "E", Page 155

Figure E (10)
Manitoba Region NIHB Annual Expenditures by Benefit
1990/91 to 1994/95

Benefit	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	17,948,000	21,605,000	24,036,000	29,345,000	32,432,000
Prescription Drugs	10,330,000	15,045,000	13,472,000	19,889,000	20,142,000
Dental Care	7,811,000	9,248,000	10,927,000	10,467,000	13,054,000
Health Care	3,615,000	5,962,000	6,940,000	4,721,000	5,431,000
Vision Care	1,227,000	1,640,000	2,337,000	1,551,000	1,305,000
TOTAL	40,931,000	53,500,000	57,712,000	65,973,000	72,364,000
% Increase	19.30	30.71	7.87	14.31	9.69

Figure E (11)
Saskatchewan Region NIHB Annual Expenditures by Benefit
1990/91 to 1994/95

Benefit	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	13,444,000	15,492,000	16,246,000	18,007,000	19,079,000
Prescription Drugs	12,875,000	13,313,000	16,110,000	20,762,000	22,919,000
Dental Care	9,669,000	9,775,000	11,164,000	12,389,000	12,196,000
Health Care	3,224,000	3,545,000	5,000,000	4,739,000	4,382,000
Vision Care	1,725,000	1,807,000	1,782,000	1,489,000	1,859,000
TOTAL	40,937,000	43,932,000	50,302,000	57,386,000	60,435,000
% Increase	20.00	7.32	14.50	14.08	5.31

The Joint AFN/MSB Task Force Report and Recommendations
Volume 1, Appendix "E", Page 157

Figure E (12)
Alberta Region NIHB Annual Expenditures by Benefit
1990/91 to 1994/95

Benefit	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	13,123,000	14,840,000	17,262,000	18,752,000	20,783,000
Prescription Drugs	17,917,000	22,856,000	25,808,000	23,526,000	24,563,000
Dental Care	9,522,000	11,800,000	14,173,000	16,274,000	17,697,000
Health Care	9,585,000	13,948,000	14,054,000	9,857,000	8,295,000
Premiums	11,800,000	14,374,000	16,339,000	18,119,000	20,105,000
Vision Care	2,554,000	3,435,000	2,565,000	2,758,000	2,966,000
TOTAL	64,501,000	81,253,000	90,201,000	89,286,000	94,409,000
% Increase	27.70	25.97	11.01	-1.01	5.74

Figure E (13)
Pacific Region NIHB Annual Expenditures by Benefit
1990/91 to 1994/95

Benefit	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	6,911,000	8,655,000	8,767,000	9,921,000	10,655,000
Prescription Drugs	11,638,000	14,808,000	19,246,000	18,615,000	21,774,000
Dental Care	14,546,000	16,258,000	17,938,000	19,684,000	19,635,000
Health Care	2,944,000	3,643,000	3,946,000	4,512,000	4,218,000
Premiums	6,946,000	8,115,000	7,989,000	8,143,000	8,456,000
Vision Care	2,959,000	3,611,000	3,824,000	2,342,000	2,474,000
TOTAL	45,944,000	55,090,000	61,710,000	63,217,000	67,212,000
% Increase	21.50	19.91	12.02	2.44	6.32

Figure E (14)
Yukon Region NIHB Annual Expenditures by Benefit
1990/91 to 1994/95

Benefit	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	957,000	1,039,000	1,111,000	1,175,000	1,275,000
Prescription Drugs	940,000	1,296,000	1,413,000	1,375,000	1,518,000
Dental Care	1,194,000	1,240,000	1,262,000	1,435,000	1,459,000
Health Care	1,241,000	1,129,000	986,000	219,000	177,000
Vision Care	198,000	164,000	143,000	87,000	166,000
TOTAL	4,530,000	4,868,000	4,915,000	4,291,000	4,595,000
% Increase	39.20	7.46	0.97	-12.70	7.08

The Joint AFN/MSB Task Force Report and Recommendations
Volume 1, Appendix "E", Page 160

Figure E (15)
Northwest Territories Region NIHB Annual Expenditures by Benefit
1990/91 to 1994/95

Benefit	1990/91	1991/92	1992/93	1993/94	1994/95
Transportation	6,683,000	9,503,000	8,835,000	9,246,000	9,086,000
Prescription Drugs	1,765,000	3,349,000	3,157,000	5,086,000	4,085,000
Dental Care	5,123,000	5,204,000	5,514,000	5,125,000	7,993,000
Health Care	1,148,000	680,000	450,000	577,000	585,000
Vision Care	0	814,000	927,000	982,000	1,088,000
TOTAL	14,719,000	19,550,000	18,883,000	21,016,000	22,837,000
% Increase	15.50	32.82	-3.41	11.30	8.66

Appendix "F"

Regional Variations and Anomalies in the Non-Insured Health Benefits

The Joint AFN/MSB Task Force on the Future Management of the Non-Insured Health Benefits Program

Appendix "F"
Regional Variations and Anomalies in the Benefits

1. Introduction

One of the Non-Insured Health Benefits (NIHB) current Program Principles is that *"there is national consistency in the NIHB Benefit Categories and in the Directives under which the Program operates".* The participants at the Consultation Sessions often stated that this principle was not valid and cited examples of differences in the types and levels of services provided by the NIHB Program in their neighbouring Regions. The participants frequently asked the obvious question "How can this happen if the NIHB Program is a National Program, based on a national set of Directives?"

The Medical Transportation Benefit was the benefit area most frequently quoted as not being provided equitably across the country. The NIHB category "Other Health Services", which deals with Allied Health Professional Services, was the other benefit area in which it was stated that there appeared to be major discrepancies in the services provided.

2. Regional Differences

a. Medical Transportation

An assessment of the levels of service provided as Medical Transportation revealed substantial variations across Canada. In one Region, for example, transportation to access Dental Services was not provided at all, while in other Regions transportation was provided to access the Dental Procedures as outlined in the Schedule of Dental Services.

In one Region, participants at the Consultation Session stated that necessary Orthodontic Services for children would be authorized by Medical Services Branch (MSB) only if the families agreed to assume the responsibility for the costs of Transportation.

The First Nations participants asked why the interpretation of the National Directives were so different across the Regions and why MSB Headquarters had not ensured that all First Nations received equitable treatment.

b. Allied Health Professional Services

The provision of Allied Health Professional Services as a Benefit under "Other Health Services", such as Physiotherapy, Chiropractic and Podiatry, varies greatly across the Regions.

Non-Insured Health Benefits Directives do not exist for the Allied Health Professional Services. MSB does not have a specific mandate to provide many of these services. Some Allied Health Professional Services have been provided as a matter of historical custom and practice which varies from Region to Region. In some Regions, some or all of these services have been provided by the provincial government, and therefore were not provided through the NIHB Program. In other Regions, the provincial governments require a co-payment for such services and this was often provided through the NIHB Program.

At the time the Joint Task Force was formed, Allied Health Professional Services were provided with prior approval and consisted of services such as:

i. Chiropractic
ii. Physiotherapy
iii. Chiropodist/Podiatrist (footcare)
iv. Home Nursing
v. Speech Therapy
vi. Acupuncture
vii. Extended Care (Level IV) co-insurance costs between 19 and 65 years of age
viii. Occupational Therapy
ix. Psychologist services.

With the introduction of the Building Healthy Communities Program, some of the Allied Health Professional Services are now provided under this Program. In recent months, using the flexibility provided through the Envelope system of budgeting, some Regions have created separate programs to provide such services and these are thus no longer provided under the NIHB Program.

c. Suggestions

The First Nations requested that a clear list of the Allied Health Professional Services be provided to them. They suggested that a Health Services Reference Guide be developed and provided at the community level so that they could be made fully aware of their entitlements, whether they be from a provincial service or through the NIHB Program.

Some participants at the Consultation Sessions understood that if the services were provided by provincial governments then MSB would not provide that service. However, they did not agree with the limited number of treatments provided under some provincial programs. It was stated that MSB should have the overall responsibility for the provision of all medically necessary treatment services. This would mean that if treatment services were still required after using the limited number of provincial services, the NIHB Program would then be responsible for any necessary additional treatments.

Appendix "G"

Overview of Current Regional Procedures

The Joint AFN/MSB Task Force
on the
Future Management
of the
Non-Insured Health Benefits Program

Appendix "G"
Overview of Current Regional Procedures

1. Introduction

Each Region has produced a set of administrative procedures based on the National Directives. These administrative procedures, which provide a full explanation of the National Directives and it's interpretation in that Region have been distributed at the First Nation community level. These procedures manuals also contain information on Benefits that are provided for which a National Directive does not exist.

2. Overview

The administrative procedures vary from Region to Region. For example, in several Regions if a Diabetic Client is prescribed a Blood Glucose Monitor in addition to writing the prescription the attending physician must complete a specific form. In other Regions only a prescription from the attending physician is required.

Some of the participants at the Consultation Sessions agreed that before medically required items were provided there should be a check to ensure that the frequency limitations were not violated. This necessity for certain items requiring prior approval from the Region was to allow for this check. There was, however, little understanding as to why a Region would implement additional administrative procedures beyond the requirement to obtain a prescription and a prior approval. Some participants stated that a formal prescription from the attending physician should be sufficient and that the need to have additional forms completed before approval was provided caused unnecessary delays in the provision of the prescribed item.

3. Suggestions

The Joint Task Force technicians did not complete a thorough analysis of the current Regional procedures. It is, however, suggested that a Health Services Reference Guide be developed for use at the community level which clearly outlines the steps required to obtain benefits.

It is also suggested that MSB review the current Regional administrative procedures to determine if the current practices are in fact causing unnecessary delays in obtaining Non-Insured Health Benefits. A further outcome of this review would be to identify a standard administrative process which could be implemented for those Benefits which are obtained solely from the NIHB Program.